

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32501

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) REBECCA D. FISHER				2. Date of Death Month Day Year OCT 11 2000		3. Time of Death 5:30am				
	4a. Facility Name (If not institution, give street and number) BLAKEHURST HEALTH CARE CENTER				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE				
Funeral Director	5. Social Security Number 216-46-3634		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 08/08/1912		9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent										
10a. State MD		10b. County BALTIMORE		10c. City, Town or Location TOWSON				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 1055 WEST JOPPA RD.				10f. Zip Code 21204		10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE			16b. Kind of Business/Industry HOMEMAKER				
17. Father's Name (First, Middle, Last) GEORGE W. DOBBIN				18. Mother's Name (First, Middle, Maiden Surname) BEATRICE DUNDERDALE							
19a. Informant's Name/Relationship (Type, Print) PENNY LEVERING (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14617 DOVER RD. REISTERSTOWN, MD. 21136.							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) ST. THOMAS GARRISON		Date 10/21/2000		20c. Location - City or Town, State OWINGS MILLS, MD.			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.							
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Emphysema Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):										Approximate Interval Between Onset and Death 20 years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number D32783		29d. Date signed (Month, Day, Year) 10/12/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH ADAMS M.D. 6701 N. CHARLES ST. EAST PAVILION TOWSON, MD. 21204.											
31. Date filed (Month, Day, Year) OCT 16 2000				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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Amended Item#19b per INFG788 10/16/2000 EW

State of Maryland / Department of Health and Mental Hygiene

00 32502

Amended Item#10b,c,d,e,f per INFG788 10/16/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Margery Phillips Filler</b>						2. Date of Death Month <b>OCTOBER</b> Day <b>9</b> Year <b>2000</b>		3. Time of Death <b>12:27 A.M.</b>						
	4a. Facility Name (If not institution, give street and number) <b>FRANKLIN SQUARE HOSPITAL CENTER</b>						4b. City, Town, or Location of Death <b>ROSEDALE</b>		4c. County of Death <b>BALTIMORE</b>						
Funeral Director	5. Social Security Number <b>212-22-8970</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 29, 1909</b>		9. Birthplace (State or Foreign Country) <b>Wales England</b>						
	Usual Residence of Decedent														
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
10e. Street and Number <b>7515 Bay Front RD</b> <b>7501 Iroquois Avenue</b>						10f. Zip Code <b>21219</b> <b>2119</b>		10g. Citizen of What Country? <b>USA</b>							
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>+5</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>concert organist</b>				16b. Kind of Business/Industry <b>musical</b>							
17. Father's Name (First, Middle, Last) <b>Issac Griffith</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Hooper</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Marion Syzmanski/daughter</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>unk</b> <b>7501 Iroquois Ave Baltimore, Md 21219</b>									
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State							
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>						22. Name and Address of Facility <b>11AM 1232 Midvalley Drive Jessup, PA 18434</b>									
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>Congestive Heart Failure</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>1 yr.</b>   <b>10 yrs</b> </td> </tr> <tr> <td>b. <b>Hypertensive Atherosclerotic Cardiovascular Disease</b></td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Congestive Heart Failure</b>	Approximate Interval Between Onset and Death  <b>1 yr.</b>  <b>10 yrs</b>	b. <b>Hypertensive Atherosclerotic Cardiovascular Disease</b>	c.	d.
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Congestive Heart Failure</b>	Approximate Interval Between Onset and Death  <b>1 yr.</b>  <b>10 yrs</b>													
	b. <b>Hypertensive Atherosclerotic Cardiovascular Disease</b>														
	c.														
	d.														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial Fibrillation</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
29b. Signature and title of certifier <b>Renee. Daut Jr MD</b>						29c. License number <b>D396660</b>		29d. Date signed (Month, Day, Year) <b>October 10, 2000</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROBERT DART, M.D. 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21231</b>															
31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>				32. Registrar's Signature <b>Renee S. Sparks</b>											



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32503

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

June Gibson

2. Date of Death

Month Day Year  
October 13, 2000

3. Time of Death

9:30 AM

4a. Facility Name (If not institution, give street and number)

404 Towson Ave.

4b. City, Town, or Location of Death

Lutherville

4c. County of Death

Baltimore Co.

Funeral  
Director

5. Social Security Number

212-20-3420

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
12-3-1925

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10e. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Lutherville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

404 Towson Ave.

10f. Zip Code

21093

10g. Citizen of What Country?

U. S. A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Person

16b. Kind of Business/Industry

Mina - Mark

17. Father's Name (First, Middle, Last)

August David Albrecht

18. Mother's Name (First, Middle, Maiden Surname)

Thelma Armstead

19a. Informant's Name/Relationship (Type, Print)

Mr. Robert D. Gibson (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

241 N. Dickinson School Road, Carlisle, Pennsylvania

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem. Gards. 10-16-00 Timonium, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Wallace S. Brant, Jr.

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.

1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertensive Cardiovascular Disease

Due to (or as a consequence of):

Year

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Pending investigation☐ Accident☐ Suicide☐ Homicide☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-17041

29d. Date signed (Month, Day, Year)

13 October 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marc Leaver MD, 1205 York Road Ste 38 Lutherville MD 21093

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 16 2000

32. Registrar's Signature

K. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Robert

Andre Herbert Gilliam

amend item 23a, 27, 28a, b, c, d, e, f per me G788 10/19/00 yf **Certificate of Death**

Reg. No.

00 32504

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

**Andre Herbert Gilliam**2. Date of Death  
Month Day Year  
**October 09, 2000**

3. Time of Death

**10:04 A.M.**Funeral  
Director

4a. Facility Name (If not institution, give street and number)

**4413 Old York Road**

4b. City, Town, or Location of Death

**Baltimore**

4c. County of Death

**N/A**

5. Social Security Number

**218-60-2563**

6. Sex

**XX** M ☐ F

7. Age (In yrs. last birthday)

**47**

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

**01-23-1953**

9. Birthplace (State or Foreign Country)

**Maryland**

Usual Residence of Decedent

10a. State

**Md.**

10b. County

**N/A**

10c. City, Town or Location

**Baltimore**

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

**4409 Old York Rd.**

10f. Zip Code

**21212**

10g. Citizen of What Country?

**USA**

11. Marital Status

☐ Never Married ☐ Married☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

**XX** Yes ☐ NoIf Yes, Give Year or Dates: **Army**

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: **Black**

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

**11 th**

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

**Laborer**

16b. Kind of Business/Industry

**Construction**

17. Father's Name (First, Middle, Last)

**Overton Gilliam**

18. Mother's Name (First, Middle, Maiden Surname)

**Irene Holmes**

19a. Informant's Name/Relationship (Type, Print)

**Marva Gilliam Gaffney (Ex-Wife)**

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

**1604 Sherwood Rd. Baltimore, Maryland 21239**

20a. Method of Disposition

**XX** Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

**Mt. Zion Cemetery**

Date

**10/14/00 Landsdowne, Maryland**

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

**Caple Funeral Service  
5502 Winner Ave. Balto., Md. 21215**

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. **MULTIPLE STAB AND CUTTING WOUNDS**

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)**at scene**

27. Manner of Death

1 ☐ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☒ Homicide

28a. Date of Injury

found: **10/9/00**

28b. Time of Injury

found: **9:55**

A

M

28c. Injury et Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred subject stabbed and cut

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found in yard

28f. Location (Street and Number or Rural Route Number, City or Town, State) **4408 Old York Rd., Baltimore, Md.**

29e. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

**Theodore M. King**

29c. License number

**O.C.M.E.**

29d. Date signed (Month, Day, Year)

**October 10, 2000**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**Theodore M. King****111 Penn Street, Baltimore, Maryland 21201**State  
Registrar

31. Date filed (Month, Day, Year)

**OCT 16 2000**

32. Registrar's Signature

**Theodore M. King**

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





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State of Maryland / Department of Health and Mental Hygiene

00 32505

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Carris Lee Goins</b>				2. Date of Death Month Day Year <b>October 13, 2000</b>				3. Time of Death <b>4:10 am</b>		
	4e. Facility Name (If not institution, give street and number) <b>Riverview Nursing Center</b>				4b. City, Town, or Location of Death <b>Essex</b>				4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>244 03 4925</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b> Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) <b>Oct. 10, 1908</b>		
	9. Birthplace (State or Foreign Country) <b>South Carolina</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Middle River</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Usual Residence of Decedent		10e. Street and Number <b>17 Honeysuckle Lane</b>		10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Courier</b>		16b. Kind of Business/Industry <b>State Health Department</b>							
17. Father's Name (First, Middle, Last) <b>John Tielman Goins</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nannie Alice Mathews</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Dale S. Goins (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>336 Grovethorn Rd. Baltimore, Md. 21220</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens Of Faith Cem.</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>							
21. Signature of Funeral Service Licensee <b>John W. Burkhardt</b>		22. Name and Address of Facility <b>Bruzdinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Md. 21221</b>									
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Respiratory failure</b> Due to (or as a consequence of): <b>b. Dementia</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>less than one week</b>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier <b>Dr. Tripathi</b>		29c. License number <b>D30661</b>		29d. Date signed (Month, Day, Year) <b>October 13<sup>th</sup> 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sitish TRIPATHI</b> <b>5601 Loch Raven Blvd. Baltimore, Md - 21239</b>											
State Registrar		31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>		32. Registrar's Signature <b>[Signature]</b>							

ORIGINAL

White

August 11

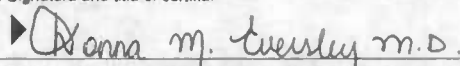
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32506

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LENORA E. GREEN</b>				2. Date of Death Month Day Year <b>OCTOBER 12<sup>th</sup> 2000</b>		3. Time of Death <b>09:08</b>	
	4a. Facility Name (If not institution, give street and number) <b>LEVINDALE HEBREW HOME</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>219-32-3259</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEP. 25, 1921</b>	
	9. Birthplace (State or Foreign Country) <b>N.C.</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number <b>3211 CLARKS LANE #314</b>		10f. Zip Code <b>21215</b>	
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>1</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>				16b. Kind of Business/Industry <b>OWN HOME</b>		17. Father's Name (First, Middle, Last) <b>MORRIS KIRSCH</b>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>SADIE CARMEL</b>				19a. Informant's Name/Relationship (Type, Print) <b>MICHAEL GREEN / SON</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2415 BRAMBLETON ROAD - BALTIMORE, MD 21209</b>	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ANSHE EMUNAH AITZ CHAIM</b>		20c. Location - City or Town, State <b>10/13/00 BALTIMORE, MD</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): <b>b. DEMENTIA</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death <b>2 YEARS</b> <b>1 YEAR</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b> 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred <b>28e. Location (Street and Number or Rural Route Number, City or Town, State)</b>			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 			
	29c. License number <b>D 054739</b>				29d. Date signed (Month, Day, Year) <b>October 12<sup>th</sup> 2000</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>2434 W. Belvedere Avenue, Baltimore Maryland 21215</b>				31. Data filed (Month, Day, Year) <b>OCT 16 2000</b>			
	32. Registrar's Signature 				33. State Registrar <b>State Registrar</b>			

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 32507

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kenneth Evans Gaines</b>				2. Date of Death Month Day Year <b>OCTOBER 14, 2000</b>		3. Time of Death <b>9:10 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL OF BALTIMORE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>City</b>		
Funeral Director	5. Social Security Number <b>217-18-1391</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar. 24, 1924</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Owings Mills</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>43 Wengate Rd.</b>		10f. Zip Code <b>21117</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Policeman</b>		16b. Kind of Business/Industry <b>Balto. Co. Police Dept</b>		17. Father's Name (First, Middle, Last) <b>George Gaines</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Gordon</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Bessie Gaines - Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>43 Wengate Rd., Owings Mills, Md. 21117</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evergreen Mem. Gardens Oct. 17, 2000 Finksburg, Md.</b>		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee <b>H. G. Schlacht</b>		22. Name and Address of Facility <b>Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>PNEUMONIA</b> Due to (or as a consequence of): f. <b>MULTIPLE MYELOMA</b> Due to (or as a consequence of): g. Due to (or as a consequence of): h. Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>TWO WEEKS</b> <b>TWO YEARS</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Patrick Burnett, M.D., PHYSICIAN</b>		29c. License number <b>RES-001</b>		29d. Date signed (Month, Day, Year) <b>OCTOBER 14, 2000</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>PATRICK BURNETT, MD SINAI HOSPITAL OF BALTIMORE</b>		31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>		32. Registrar's Signature <b>Geneva B. Sparks</b>					

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 32508

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Charles Joseph Guetler				2. Date of Death Month Day Year October 9 2000		3. Time of Death 10:10 PM			
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A			
Funeral Director	5. Social Security Number 219-18-9137		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) November 13 1922			
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State: Maryland 10b. County: N/A 10c. City, Town or Location: Baltimore 10d. Inside City Limits: 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		11. Street and Number 524 N. Charles Street		12. Zip Code 21201			
13. Citizen of What Country? United States		14. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		15. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		16. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		17. Race - American Indian, Black, White, etc. Specify: White		
18. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1		19. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager		20. Kind of Business/Industry Food Service		21. Father's Name (First, Middle, Last) Unknown		22. Mother's Name (First, Middle, Maiden Surname) Unknown		
23. Informant's Name/Relationship (Type, Print) Jean C. Bronson (Step-Daughter)				24. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6934 Orchid Lane Dallas, Texas 75230						
25. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				26. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens		27. Date 10/13/00		28. Location - City or Town, State Timonium, Maryland		
29. Signature of Funeral Service Licensee Stewart T. Zittel				30. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212						
31. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Probable Cardiac Arrhythmia Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease Diabetes Mellitus				Approximate Interval Between Onset and Death 4 hrs						
32. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Peripheral Vascular Disease				33. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
34. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				35. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
36. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				37. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
38. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				39. Date of Injury (Month, Day, Year) M		40. Time of Injury M		41. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
42. Describe how injury occurred				43. Location (Street and Number or Rural Route Number, City or Town, State)						
44. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				45. Signature and title of certifier S. Ann		46. License number D30641		47. Date signed (Month, Day, Year) October 10, 2000		
48. Name and address of person who completed cause of death (Item 23e) (Type, Print) Ramesh Sabapathi, M.D. 201 Back River Neck Road Suite 109 Baltimore, MD 21221				49. Date filed (Month, Day, Year) OCT 16 2000					50. Registrar's Signature B. Sparks	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
important: if item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

00 32509

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARIE D. HOWE				2. Date of Death Month Day Year October 13, 2000				3. Time of Death 245 pm	
	4a. Facility Name (If not institution, give street and number) FRANKLIN Square Hospital Center				4b. City, Town, or Location of Death ROSEDALE				4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 217262523		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) 07/29/20		9. Birthplace (State or Foreign Country) DELAWARE	
	Usual Residence of Decedent									
10a. State MD		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number 1234 FRAILEY WAY				10f. Zip Code 21205		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER				16b. Kind of Business/Industry OWN HOME		
17. Father's Name (First, Middle, Last) WALTER DYER				18. Mother's Name (First, Middle, Maiden Surname) EMMA TARR						
19a. Informant's Name/Relationship (Type, Print) DIANE I. BLEVINS / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1907 HEMLOCK ROAD EDGEWOOD, MD 21040						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS OF FAITH		Date 10/16/00		20c. Location - City or Town, State BALTIMORE, MARYLAND				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE BALTIMORE, MD 21237						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death)		a. Chronic Obstructive Lung Disease Due to (or as a consequence of):						Approximate Interval Between Onset and Death 10 years		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):								
		c. Due to (or as a consequence of):								
		d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Dr. Marco Zamora MD				29c. License number D40819		29d. Date signed (Month, Day, Year) October 13, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Marco Zamora 9000 FRANKLIN Square Drive Baltimore, Maryland										
31. Date filed (Month, Day, Year) OCT 16 2000		32. Registrar's Signature 								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32510

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George William Hauser				2. Date of Death Month Day Year OCTOBER 12, 2000				3. Time of Death 21:11 PM	
	4a. Facility Name (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL				4b. City, Town, or Location of Death Rossville				4c. County of Death BALTIMORE	
Funeral Director	5. Social Security Number 217-14-6150		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 22, 1923		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 7 Valley Arbor Court, Apt. "C"				10f. Zip Code 21221		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bus Driver			16b. Kind of Business/Industry Transportation		
	17. Father's Name (First, Middle, Last) George Hauser				18. Mother's Name (First, Middle, Maiden Surname) Blanche Wilson					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) George W. Hauser, Jr. (son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1908 Sue Avenue, Essex, Maryland 21221					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn Cemetery		Date 10/16/2000		20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility Bruzdinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, MARYLAND, 21221					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.										
29b. Signature and title of certifier Stephen S. Radentz, M.D.				29c. License number OCME		29d. Date signed (Month, Day, Year) OCTOBER 13, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) OCT 18 2000		32. Registrar's Signature [Signature]								

ORIGINAL







ASP amend item 23a,b,27,28a,b,c,d,e,f per me G790 12/1/00

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALEXIS HARTMAN</b>				2. Date of Death Month Day Year <b>OCTOBER 11 2000</b>		3. Time of Death <b>10:30 A</b>	
	4a. Facility Name (If not institution, give street and number) <b>HARFORD MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>HAVRE DE GRACE</b>		4c. County of Death <b>HARFORD</b>	
Funeral Director	5. Social Security Number <b>UNAVAILABLE</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. Months Days <b>4 1</b>		8. Date of Birth (Month, Day, Year) <b>6/10/00</b>	
	9. Birthplace (State or Foreign Country) <b>WISCONSIN</b>		10a. State <b>MD</b>		10b. County <b>HARFORD</b>		10c. City, Town or Location <b>ABERDEEN</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>2815 MIDDLEBORO COURT</b>		10f. Zip Code <b>21005</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>		16b. Kind of Business/Industry <b>N/A</b>			
	17. Father's Name (First, Middle, Last) <b>MICHAEL HARTMAN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>KIM KURTH</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>MICHAEL &amp; KIM HARTMAN PARENTS</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2815 MIDDLEBORO COURT ABERDEEN, MD 21005</b>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY, INC.</b>		20c. Location - City or Town, State <b>10/13/00 CATONSVILLE, MD</b>			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>THE JOHNSON FUNERAL HOME, P.A.</b>		22. Name and Address of Facility <b>8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>ASPHYXIA</b> Due to (or as a consequence of): b. <b>SUFFOCATION</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>found 10/11/00</b>		28b. Time of Injury <b>found at approx. 8:00</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>home</b>		28d. Describe how injury occurred suffocation					
	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2815 Middleboro Ct., Apt. C Aberdeen, MD</b>							
State Registrar	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number <b>O.C.M.E</b>	
	29d. Date signed (Month, Day, Year) <b>OCTOBER 12, 2000</b>							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J Chute</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>							
31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>		32. Registrar's Signature 						




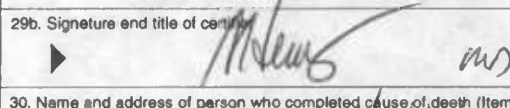

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State of Maryland / Department of Health and Mental Hygiene

00 32512

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GEORGE HENSON</b>		2. Date of Death Month <b>10</b> Day <b>10</b> Year <b>00</b>		3. Time of Death <b>1145A</b>
	4a. Facility Name (If not Institution, give street and number) <b>Catonsville Commons</b>		4b. City, Town, or Location of Death <b>Catonsville</b>		4c. County of Death <b>Baltimore</b>
Funeral Director	5. Social Security Number <b>214-01-9517</b>	6. Sex <b>15M 20F</b>	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>8/31/18</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
Usual Residence of Decedent					
10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>CATONSVILLE</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>166 WINTERS LANE</b>		10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>41/43</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MECHANIC</b>		16b. Kind of Business/Industry <b>MILLER CHEVROLET</b>	
17. Father's Name (First, Middle, Last) <b>SAMUEL HENSON</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>SADIE HENSON</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Alton Morrison/Friend</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>166 Winters Lane, Catonsville, Md., 21228</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST</b>		20c. Location - City or Town, State <b>10-16-00 OWINGS MILLS, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>Chronic Obstructive Pulmonary Disease Unknown</b> Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pneumonia</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M <input type="checkbox"/> Yes <input type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
28f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>DD569</b>		29d. Date signed (Month, Day, Year) <b>10/12/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Allen Hettelman 1838 Green Tree Rd #300</b>					
31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>		32. Registrar's Signature 			



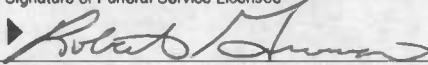
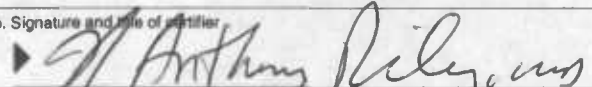
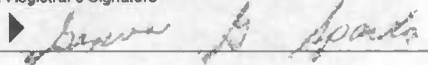
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State of Maryland / Department of Health and Mental Hygiene

00 32513

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EARL JAFFE</b>		2. Date of Death Month <b>OCTOBER</b> Day <b>12</b> Year <b>2000</b>		3. Time of Death <b>1:50 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>HOSPICE OF BALTIMORE - GILCHRIST CENTER</b>		4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>220-01-5311</b>	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>AUG. 7, 1920</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
	10e. Street and Number <b>5815 BERKELEY AVENUE</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>SALES</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>RETAIL</b>
	17. Father's Name (First, Middle, Last) <b>SAMUEL JAFFE</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>HILDA WEISS</b>		19. Informant's Name/Relationship (Type, Print) <b>IRENE JAFFE / WIFE</b>
Physician /Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5815 BERKELEY AVENUE - BALTIMORE, MD 21215</b>		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HILLTOP SERVICE CORP.</b>
	20c. Date <b>10/13/00</b>		20d. Location - City or Town, State <b>TOWSON, MD</b>		21. Signature of Funeral Service Licensee 
	22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>congestive heart failure</b> Due to (or as a consequence of):  b. <b>coronary artery disease</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>6 years</b> <b>years</b>		
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	28d. Describe how injury occurred
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	29b. Signature and Title of Certifier 		29c. License number <b>D25205</b>	29d. Date signed (Month, Day, Year) <b>October 12, 2000</b>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>W.A. Riley GBMC 16701 N. Charles St. Balto. md 21204</b>				
	31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>	32. Registrar's Signature 			

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32514

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERT HENRY KIRCKHOFF				2. Date of Death Month Day Year October 15, 2000		3. Time of Death 11:40 PM	
	4a. Facility Name (If not institution, give street and number) Hospice of Baltimore Gilchrist Center				4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 705-10-5697		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 31, 1917	
	9. Birthplace (State or Foreign Country) Md.		10a. State Md.		10b. County Baltimore		10c. City, Town or Location Lutherville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 16 Felton Rd.		10f. Zip Code 21093	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW-II	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Customer Service Manager				16b. Kind of Business/Industry CSX Corp.		17. Father's Name (First, Middle, Last) Henry Paret Kirckhoff	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Frieda Marie Poetzsch				19a. Informant's Name/Relationship (Type, Print) Mr. Robert G. Kirckhoff/son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18819 York Rd. Parkton, Md. 21120	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		20c. Location - City or Town, State 10/17/00 Towson, Md.	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service licensee 				22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cirrhosis of Liver Due to (or as a consequence of): b. Hemachromatosis Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death years years			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 			
	29c. License number 025205				29d. Date signed (Month, Day, Year) October 16, 2000			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 29a) (Type, Print) W. A. Riley GBMC 6701 N. Charles St. Balto. Md 21204				31. Date filed (Month, Day, Year) OCT 16 2000			
	32. Registrar's Signature 				33. Registrar's Title Registrar			

ORIGINAL

1862

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State of Maryland Department of Health and Mental Hygiene

AMEND ITEM: #20B PER F.H. G788 10-16-00 **Certificate of Death**

Reg. No.

00 32515

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edith Lannon</b>				2. Date of Death Month <b>October</b> Day <b>15</b> Year <b>2000</b>		3. Time of Death <b>8:10PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Brightwood Center</b>				4b. City, Town, or Location of Death <b>Brooklandville</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>217-38-1767</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>95</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 29 1905</b>	
	9. Birthplace (State or Foreign Country) <b>New Jersey</b>		10a. State <b>Virginia</b>		10b. County <b>Fairfax</b>		10c. City, Town or Location <b>Burke</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>5801 Cove Landing Rd. #208</b>		10f. Zip Code <b>22015</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Own Home</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>John William Cooke</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Cecelia Mitch</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Marlene Watson/ Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5801 Cove Landing Rd. #208 Burke, Va. 22015</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>		20c. Location - City or Town, State <b>Towson, Md.</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>						Approximate Interval Between Onset and Death <b>YLP</b>	
	Due to (or as a consequence of):							
Physician /Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined							
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)						28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred						28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier 	
	29c. License number <b>1720333</b>							
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <b>10/16/00</b>						30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>R. J. JONES MD 1835 ANNEENTREE RD PIKENILLE MD 21208</b>	
	31. Data filed (Month, Day, Year) <b>OCT 16 2000</b>							
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature 						33. Date of filing (Month, Day, Year) <b>OCT 16 2000</b>	
	34. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>R. J. JONES MD 1835 ANNEENTREE RD PIKENILLE MD 21208</b>							

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 32516

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

IRENE ELIZABETH LYLES

2. Date of Death  
Month Day Year

OCTOBER 11 2000 6:24AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

JOSEPH RICHIE HOSPICE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

214-40-8927

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC. 16, 1944

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

205 NORTH CHAPEL STREET

10f. Zip Code

21231

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☒ Navar Marriad 2 ☐ Merried  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12<sup>TH</sup> GRADE

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PHONE TECHNICIAN

16b. Kind of Business/Industry

TELEPHONE COMPANY

17. Father's Name (First, Middle, Last)

HERMAN

18. Mother's Name (First, Middle, Maiden Surname)

JANIE (MN - UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

LAUREN BROWN (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2006 WESTWOOD AVENUE, BALTIMORE, MD. 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEMETERY

Data

10-16-00

20c. Location - City or Town, State

LANSDOWNE, MARYLAND

21. Signature of Funeral Service Licensee

John Williams

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME  
2140 N. FULTON AVE. BALTIMORE, MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. AIDS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William Benedict, MD

29c. License number

D000 8503

29d. Date signed (Month, Day, Year)

10/11/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Benedict, MD 6565 N. Charles St 21204

31. Date filed (Month, Day, Year)

OCT 16 2000

32. Registrar's Signature

Beauva B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

IRENE LYLES 624 11 Oct 2000 6 AM





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

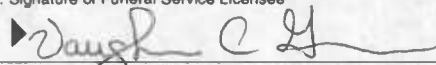
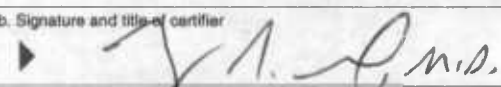
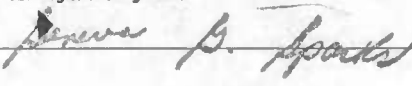
CHESTER LEWIS

State of Maryland / Department of Health and Mental Hygiene

00 32517

amend item 23a,27,28a,b,c,d,e,f per me G788 10/19/00 yr **Certificate of Death**

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHESTER T. LEWIS</b>				2. Date of Death Month Day Year <b>OCT. 7, 2000</b>		3. Time of Death <b>1718 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>BON SECOUR HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>217-78-4760</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>40</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>04-29-60</b>	
	9. Birthplace (State or Foreign Country) <b>SC</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>4902 CORDELIA AVENUE</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH GRADE</b>		College (14 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CONSTRUCTION WORKER</b>		16b. Kind of Business/Industry <b>CONSTRUCTION</b>	
	17. Father's Name (First, Middle, Last) <b>JOHN LEWIS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>HATTIE CLARK</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>DIANE LEWIS / SISTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4902 CORDELIA AVE. BALTO MD. 21215</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CREMATION SERVICES</b>		20c. Location - City or Town, State <b>10/12/00 BALTO. MD</b>		20d. Date	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>CREMATION SERVICES 5151 BALTO. NATL PIKE, BALTO. MD. 21229</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>NARCOTIC AND ETHANOL INTOXICATION</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>found: 10/7/00</b>		28b. Time of Injury (Month, Day, Year) <b>found: 4:40 P M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>found: residence</b>				28d. Describe how injury occurred <b>unknown</b>			
	28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1623 Bakbury Court Baltimore, Maryland</b>				28g. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>OCT. 8, 2000</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY G. RIPPKE, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>							
	31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>				32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32518

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RAYMOND Joseph MAROCCO, Sr.</b>		2. Date of Death Month <b>OCTOBER</b> Day <b>15</b> Year <b>2000</b>		3. Time of Death <b>10<sup>50</sup> AM</b>
	4a. Facility Name (If not institution, give street and number) <b>OAK CREST VILLAGE CARE CENTER</b>		4b. City, Town, or Location of Death <b>BALTO.</b>		4c. County of Death <b>BALTO</b>
Funeral Director	5. Social Security Number <b>220-14-0113</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months <b></b> Days <b></b>	If Under 24 Hrs. Hours <b></b> Min. <b></b>
	8. Date of Birth (Month, Day, Year) <b>October 30, 20</b>		9. Birthplace (State or Foreign Country) <b>Baltimore, Md.</b>		
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Baltimore Co.</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>8810 Walther Blvd. Apt. 1321</b>			10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>W.W.II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b></b>	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self Employed Contractor</b>		16b. Kind of Business/Industry <b>Construction</b>	
17. Father's Name (First, Middle, Last) <b>Pio Joseph Marocco, Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Rosa D'Ercole</b>		
19a. Informant's Name/Relationship (Type, Print) (Wife) <b>Mrs. Anita Laura (nee Cipolla) Marocco</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8810 Walther Blvd. Apt. 1321 Baltimore, Md. 21234</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lorraine Park Cemetery</b>		20c. Location - City or Town, State <b>10/18/00 Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Jeffrey L. Gair</b>		22. Name and Address of Facility <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Chronic obstructive Pulmonary Disease</b> Due to (or as a consequence of): a. <b></b> Due to (or as a consequence of): b. <b></b> Due to (or as a consequence of): c. <b></b> Due to (or as a consequence of): d. <b></b>					
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pneumonia</b> <b>Congestive Heart Failure</b>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b></b>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b></b>		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b></b>			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b></b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b></b>			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Fred Sirkis MD</b>		29c. License number <b>D22645</b>		29d. Date signed (Month, Day, Year) <b>10/15/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FRED SIRKIS MD, 8800 WALTHER BLVD. PARKVILLE MD, 21234</b>					
31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>		32. Registrar's Signature <b>Beverly S. Sparks</b>			

ORIGINAL



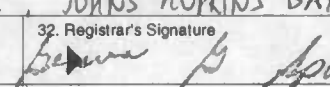
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32519

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELSIE MEOMARTINO</b>		2. Date of Death Month <b>OCTOBER</b> Day <b>11</b> Year <b>2000</b>		3. Time of Death <b>2:00 pm</b>
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>216-01-2676</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>8-18-1915</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>RASPEBURG</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number <b>5458 CEDONIA AVENUE</b>			10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>ASSISTANT MANAGER</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry <b>TWO GUYS JEWELRY STORE</b>	
17. Father's Name (First, Middle, Last) <b>MARTIN VANHORN</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>ALBERTA (DORSEY)</b>		
19a. Informant's Name/Relationship (Type, Print) <b>HOWARD MEOMARTINO (HUSBAND)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5458 CEDONIA AVENUE BALTIMORE, MD 21206</b>		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		20c. Location - City or Town, State <b>10/12/00 BALTIMORE, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 21237</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>INTRACRANIAL HEMORRHAGE</b>			Approximate Interval Between Onset and Death <b>1 DAY</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ASTHMA</b>					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier  <b>Resident Physician</b>		29c. License number <b>P11949</b>		29d. Date signed (Month, Day, Year) <b>OCTOBER 11 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ABHAY MOGHEKAR, JOHNS HOPKINS BAYVIEW MEDICAL CENTER, BALTIMORE, MD</b>					
31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32520

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Fannie Virginia Moore</b>				2. Date of Death Month <b>10</b> Day <b>12</b> Year <b>00</b>		3. Time of Death <b>345 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Noble House Nursing Home</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>214-24-0823</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>02-20-23</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>2842 Woodbrook Avenue</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>10th Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse</b>		16b. Kind of Business/Industry <b>Hospital</b>			
	15. Decedent's Education (Specify only highest grade completed) <b>College (1-4 or 5+)</b> <b>NA</b>		17. Father's Name (First, Middle, Last) <b>Rufus Langton</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Leslie Valantine</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mary Brown</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1711 Mapleshade Lane Richmond, VA. 23227</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Mem. Pk. Cem. 10-17-2000 Arbutus, MD</b>		20c. Location - City or Town, State <b>MD</b>		20d. Date <b>10-17-2000</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Gladys W...</b>				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM. C. March FH 1101 E. North Avenue</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Stroke</b> Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Decubitus Ulcer</b>				Approximate Interval Between Onset and Death <b>6 Months</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Decubitus Ulcer</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>10/13/00</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <b>MD</b>				29c. License number <b>D38675</b>		29d. Date signed (Month, Day, Year) <b>10/13/00</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOEL MESHULAM 301 ST PAUL PL SUITE 605 BALTIMORE MD 21202</b>							
	31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>				32. Registrar's Signature <b>[Signature]</b>			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32521

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jacob Miles

2. Date of Death  
Month Day Year  
Oct. 11, 20003. Time of Death  
13:02pm

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

216-24-7622

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
03-04-31

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1112 Lakewood Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th Grade

College (1-4 or 5+)

NA

16. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Local Union #557

17. Father's Name (First, Middle, Last)

William Miles

18. Mother's Name (First, Middle, Maiden Surname)

Frances Carver

19a. Informant's Name/Relationship (Type, Print)

Carrie Miles

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1112 Lakewood Avenue Baltimore, MD. 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Voshell Mem. Gardens 10-16-2000 Dundalk, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Bernard D. Johnson

22. Name and Address of Facility

Baltimore, Maryland 21202  
WM.C.March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARYTHMIA

Due to (or as a consequence of):

b. ENDSTAGE RENAL DISEASE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Klapper MD

29c. License number

D30575

29d. Date signed (Month, Day, Year)

10/16/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 S. GREEN ST BALTIMORE MD 21201

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 16 2000

32. Registrar's Signature

Bernard D. Johnson

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32522

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>John F. Miller</u>		2. Date of Death Month <u>October</u> Day <u>12</u> Year <u>2000</u>		3. Time of Death <u>1:00 AM</u>
	4a. Facility Name (If not institution, give street and number) <u>1141 Linden Ave.</u>		4b. City, Town, or Location of Death <u>Arbutus</u>		4c. County of Death <u>Baltimore</u>
Funeral Director	5. Social Security Number <u>29-18-2710</u>	6. Sex <u>M</u> <input type="checkbox"/> F <input type="checkbox"/>	7. Age (In yrs. last birthday) <u>78</u> Yrs.	If Under 1 Year Months <u>0</u> Days <u>0</u>	If Under 24 Hrs. Hours <u>0</u> Min. <u>0</u>
	8. Date of Birth Month <u>11</u> Day <u>19</u> Year <u>22</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <u>MD</u>	10b. County <u>Baltimore</u>	10c. City, Town or Location <u>Arbutus</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <u>1141 Linden Ave.</u>		10f. Zip Code <u>21227</u>		10g. Citizen of What Country? <u>United States</u>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <u>01-02-43</u> <u>01-05-46</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <u>white</u>				
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>research Biologist</u>		16b. Kind of Business/Industry <u>Biology</u>
	17. Father's Name (First, Middle, Last) <u>Lawrence G. Miller</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>Katherine Marie Huisler</u>		
	19a. Informant's Name/Relationship (Type, Print) <u>Margaret E. Miller/wife</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1141 Linden Ave. Arbutus MD 21227</u>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>London Park Cemetery</u>		20c. Location - City or Town, State <u>Baltimore MD</u>
	21. Signature of Funeral Service Licensee <u>Sean P. Ambrose</u>		22. Name and Address of Facility <u>Ambrose Funeral Home, Inc.</u> <u>1328 Sulphur Spring Rd. Arbutus MD 21227</u>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of): <u>a. Congestive Heart Failure</u>  <u>b. Chronic Renal Failure</u>  Due to (or as a consequence of): <u>c. Diabetes Mellitus</u>  Due to (or as a consequence of): <u>d. Coronary Artery Disease</u>				Approximate Interval Between Onset and Death <u>Three years</u>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
State Registrar	29b. Signature and title of certifier <u>R. Walsh MD</u>		29c. License number <u>D38662</u>		29d. Date signed (Month, Day, Year) <u>10/13/00</u>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Richard J. Walsh 4660 Wilkens Ave. Baltimore MD 21229</u>				
	31. Date filed (Month, Day, Year) <u>OCT 16 2000</u>		32. Registrar's Signature <u>Benjamin S. Sparks</u>		

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32523

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Adtrian Marie Morris

2. Date of Death  
Month Day Year  
October 09, 20003. Time of Death  
13:19

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

213-30-3398

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

4-1-1931

9. Birthplace (State or Foreign Country)

Va

Usual Residence of Decedent

10a. State

Md

10b. County

Balto

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

500 Virginia Avenue

10f. Zip Code

21221

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th grade

College (1-4or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Tech

16b. Kind of Business/Industry

School

17. Father's Name (First, Middle, Last)

James Brown

18. Mother's Name (First, Middle, Maiden Surname)

Susie V. Brown

19a. Informant's Name/Relationship (Type, Print)

Elka Tracey Perry-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4503 Brightwater Court Apt 3 G Baltimore, Md 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Druid Ridge Cemetery

Date

10-14-00

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

March F/H West

4300 Wabash Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pulmonary embolism

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Day

b. Pancreatitis and pancreatic pseudocyst

Due to (or as a consequence of):

Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Bilateral pleural effusions, peritoneal effusion

obesity

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D27740

29d. Date signed (Month, Day, Year)

October 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert A. Palermo, M.D.

Greater Baltimore Medical Center

6701 N. Charles Street

Baltimore, MD 21204

31. Date filed (Month, Day, Year)

OCT 16 2000

32. Registrar's Signature

Robert A. Palermo

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

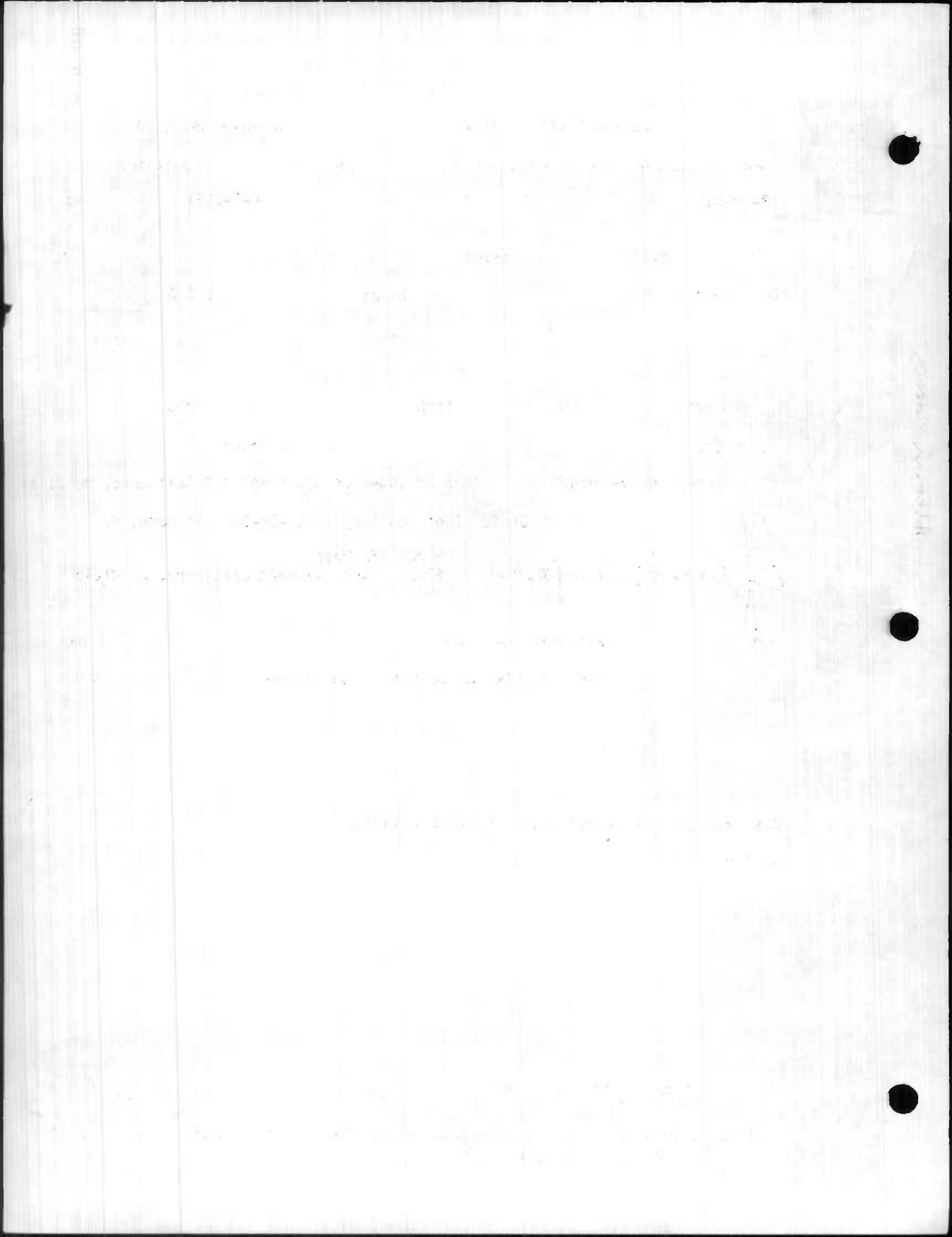
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Adtrian Morris



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32524

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>CLAUDE MARROW</u>			2. Date of Death Month <u>OCTOBER</u> Day <u>11</u> Year <u>2000</u>			3. Time of Death <u>17:39</u>												
	4a. Facility Name (If not institution, give street and number) <u>JOHNS HOPKINS BAYVIEW Medical Center</u>			4b. City, Town, or Location of Death <u>Baltimore</u>			4c. County of Death												
Funeral Director	5. Social Security Number <u>214-56-6735</u>			6. Sex <u>1</u> M <u>2</u> F			7. Age (In yrs. last birthday) <u>49</u> Yrs.												
	8. Date of Birth (Month, Day, Year) <u>12-9-50</u>			9. Birthplace (State or Foreign Country) <u>MD</u>															
Usual Residence of Decedent																			
10a. State <u>MD</u>			10b. County			10c. City, Town or Location <u>BALTIMORE</u>			10d. Inside City Limits <u>1</u> Yes <u>2</u> No										
10e. Street and Number <u>6213 SHIPVIEW WAY</u>			10f. Zip Code <u>21224</u>			10g. Citizen of What Country? <u>USA</u>													
11. Marital Status <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <u>1</u> Yes <u>2</u> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> Yes <u>2</u> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u>										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>College</u>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>CUSTODIAN</u>			16b. Kind of Business/Industry <u>MAINTENANCE</u>													
17. Father's Name (First, Middle, Last) <u>CLAUDE MARROW</u>						18. Mother's Name (First, Middle, Maiden Surname) <u>REBECCA GUINITCHETT</u>													
19a. Informant's Name/Relationship (Type, Print) <u>GEORGIA MARROW</u>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6213 SHIPVIEW WAY BALTIMORE MD 21224</u>													
20a. Method of Disposition <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>METRO CREMATORY INC</u>			20c. Location - City or Town, State <u>10-16-00 BALTIMORE MD</u>													
21. Signature of Funeral Service Licensee <u>Willis Howell</u>			22. Name and Address of Facility <u>HOWELL FUNERAL HOME</u> <u>4600 LIBERTY HEIGHTS AVENUE</u> <u>BALTIMORE, MARYLAND 21207</u>																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <u>PNEUMONIA</u></td> <td>Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. _____</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____</td> <td>Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <u>PNEUMONIA</u>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b. _____	Due to (or as a consequence of):	c. _____	Due to (or as a consequence of):	d. _____	Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <u>PNEUMONIA</u>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death																
	b. _____	Due to (or as a consequence of):																	
	c. _____	Due to (or as a consequence of):																	
	d. _____	Due to (or as a consequence of):																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <u>1</u> Yes <u>2</u> No <u>3</u> Probably <u>4</u> Unknown													
						24a. Was an autopsy performed? <u>1</u> Yes <u>2</u> No		24b. Were autopsy findings available prior to completion of cause of death? <u>1</u> Yes <u>2</u> No											
25. Was case referred to medical examiner? <u>1</u> Yes <u>2</u> No			26. Place of Death (Check only one) Hospital: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA Other: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)																
27. Manner of Death <u>1</u> Natural <u>5</u> Pending investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <u>1</u> Yes <u>2</u> No		28d. Describe how injury occurred										
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <u>1</u> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier <u>Wang, MD</u>			29c. License number <u>21007</u>			29d. Date signed (Month, Day, Year) <u>OCTOBER 11, 2000</u>													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>William Hung MD. 4904 KASTLEMAN AVENUE BALTIMORE, MARYLAND 21224</u>																			
31. Date filed (Month, Day, Year) <u>OCT 16 2000</u>			32. Registrar's Signature <u>B. Sparks</u>																

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32525

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Robert Madden</b>				2. Date of Death Month Day Year <b>Oct. 12, 2000</b>		3. Time of Death <b>2 pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>5 Staley Court</b>				4b. City, Town, or Location of Death <b>Reisterstown</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>216-54-4832</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>49</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 28, 1951</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Reisterstown</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>5 Staley Court</b>		10f. Zip Code <b>21136</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1971 - 1977</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Diesel Mechanic</b>		16b. Kind of Business/Industry <b>U.S. Coast Guard</b>		17. Father's Name (First, Middle, Last) <b>Richard Madden</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Hepple</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Helen Madden - Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 Staley Ct., Reisterstown, Md. 21136</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans Cem. Oct. 16, 2000 Owings Mills, Md.</b>		20c. Location - City or Town, State		21. Signature of Funeral Service Licensee <b>H. J. Schmitt</b>		22. Name and Address of Facility <b>Eckhardt Funeral Chapel 21117 11605 Reisterstown Rd., Owings Mills, Md.</b>	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Huntington's Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death <b>15 years</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>B45526</b>		29d. Date signed (Month, Day, Year) <b>10/13/2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ADAM ROSENBLAT M.D. Johns Hopkins Hospital</b>		31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>		32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL

John - Robert Ladden

Oct. 12, 1937

State Court

Relationship

214-75-6-12

As

Dec. 12, 1937

Relationship

State Court

214-75-6-12

State Court

U.S.A.

1937 - 1938

White

12

Relationship

U.S. Court

Relationship

Relationship

State Court, 214-75-6-12

State Court - 214

Relationship - 214-75-6-12, 1937 - 1938

1937

Relationship - 214-75-6-12

Relationship - 214-75-6-12, 1937 - 1938



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32526

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANN CHRISTOPHER MARTIN</b>				2. Date of Death Month Day Year <b>October 9, 2000</b>		3. Time of Death <b>12:41PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>16 Country Club Lane</b>				4b. City, Town, or Location of Death <b>Phoenix</b>		4c. County of Death <b>Baltimore,</b>	
Funeral Director	5. Social Security Number <b>213-32-2603</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 12, 1926</b>	
	9. Birthplace (State or Foreign Country) <b>Tennessee</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Phoenix</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>16 Country Club Lane</b>		10f. Zip Code <b>21131</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse</b>		16b. Kind of Business/Industry <b>Hospital</b>			
	17. Father's Name (First, Middle, Last) <b>Daniel McCall Christopher</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Gladys Daisy Duffer</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Kenneth C Martin Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16 Country Club Lane Phoenix, Maryland 21131</b>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Cemetery</b>		20c. Location - City or Town, State <b>10-10-00 Baltimore, Maryland</b>			
	21. Signature of Funeral Service Licensee <i>Bennis Stephen Kenaka</i>				22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute myocardial Infarction</b> Due to (or as a consequence of): <b>b. Diabetes mellitus</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>congestive heart failure</b>								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Attending MD</i>		29c. License number <b>037016</b>		29d. Date signed (Month, Day, Year) <b>October 10, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kenneth Green 6701 North Charles Street Towson MD 21204 Suite 4105</b>								
31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 32527

AMEND#20B PER F.H. G788 10-24-2000

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Leslie Powell</b>				2. Date of Death Month <b>October</b> Day <b>15</b> Year <b>2000</b>				3. Time of Death <b>9:22am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Joseph Ritchie Hospice</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>219-62-6035</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>44</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 26, 1956</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>529 Brisbane Road</b>				10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Painter</b>				16b. Kind of Business/Industry <b>Home Improvement</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>James Ross McCoy</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Mae Williams</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Brenda L. Powell-Jackson (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>529 Brisbane Road Baltimore, Maryland 21229</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		Date <b>10/20/00</b>		20c. Location - City or Town, State <b>LANSDOWNE MARYLAND</b> <b>Arbutus, Maryland</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Cape Funeral Service</b> <b>5502 Winner Avenue Baltimore, Maryland 21215</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Non small cell carcinoma lung</b> Due to (or as a consequence of): <b>Brain metastasis</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Non small cell carcinoma lung</b> Due to (or as a consequence of): <b>Brain metastasis</b> Due to (or as a consequence of): <b>Non small cell carcinoma lung</b>								Approximate Interval Between Onset and Death <b>6/00</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>	
State Registrar	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier <b>Katherine Hansen MD.</b>				29c. License number <b>D0035712</b>				29d. Date signed (Month, Day, Year) <b>10/15/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Ritchie Hospice 820 N. Eubank Pl. Balto MD 21201</b>										
31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>				32. Registrar's Signature 						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32528

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Hazel Catherine Reynolds				2. Date of Death Month Day Year October 14, 2000				3. Time of Death 11:15 p.m.	
	4a. Facility Name (If not institution, give street and number) 810 Briarhill Place, Apartment "C"				4b. City, Town, or Location of Death Essex				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 224-22-8110		8. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	6. Date of Birth Month Day Year Feb. 7, 1920		9. Birthplace (State or Foreign Country) Virginia		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Essex	
Usual Residence of Decedent										
10a. Street and Number 810 Briarhill Place, Apartment "C"										
10f. Zip Code 21221										
10g. Citizen of What Country? U.S.A.										
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced										
12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:										
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:										
14. Race - American Indian, Black, White, etc. Specify: White										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker 16b. Kind of Business/Industry Own Home										
17. Father's Name (First, Middle, Last) Samuel Henry Coffman										
18. Mother's Name (First, Middle, Maiden Surname) Cora Elizabeth Littin										
19a. Informant's Name/Relationship (Type, Print) Clayton James Reynolds (husband)										
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 Briarhill Place, Apt. C, Essex, Md. 21221										
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)										
20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem. Gardens										
20c. Location - City or Town, State 10/18/2000 Baltimore, Maryland										
21. Signature of Funeral Service Licensee										
22. Name and Address of Facility Bruzdziński Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive heart failure Due to (or as a consequence of): Atrial Fibrillation Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last One week one year										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier										
29c. License number D15408										
29d. Date signed (Month, Day, Year) 10/16/00										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DENIS MACDONALD M.D. 2801 HUDSON ST BALTO MD 21224										
31. Date filed (Month, Day, Year) OCT 16 2000										
32. Registrar's Signature										

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32529

Amend Item 10a,c,e,f, per FH, 11/8/00,G789,gap

Certificate of Death

Reg. No.

John S.L. ROSZEL 12:55AM 10 Oct 2000

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Physician /Medical Examiner  
Funeral Director

1. Decedent's Name (First, Middle, Last) <b>JOHN SOUTHGATE LEMMON ROSZEL</b>						2. Date of Death Month Day Year <b>OCTOBER 10, 2000</b>		3. Time of Death <b>12:55 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>JOSEPH RICHEY HOSPICE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>			
5. Social Security Number <b>214-03-4933</b>		6. Sex <b>XX</b> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>01-28-1913</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
Usual Residence of Decedent									
10a. State <b>Fla.</b> <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Sun City Center</b> <b>BALTIMORE CITY</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1612 Council Drive</b> <b>3601 GREENWAY, APT. 2 10</b>				10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YEARS</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PERSONEL DIRECTOR</b>			16b. Kind of Business/Industry <b>OLIN CORPORATION</b>		
17. Father's Name (First, Middle, Last) <b>R. JULIAN ROSZEL</b>						18. Mother's Name (First, Middle, Maiden Summe) <b>JANET LEMMON</b>			
19a. Informant's Name/Relationship (Type, Print) <b>ANN F. BRENT ROSZEL (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3601 GREENWAY, BALTIMORE, MARYLAND, 21218</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREEN MOUNT CREMATORY</b>		Date <b>10-11</b>		20c. Location - City or Town, State <b>BALTIMORE, MD. 21202</b>			
21. Signature of Funeral Service Licensee <b>R. A. Rutz</b>				22. Name and Address of Facility <b>HENRY W. JENKINS AND SONS COMPANY</b> <b>4905 YORK ROAD, BALTIMORE, MARYLAND, 21212</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Carcinoma Lung.</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>1 month</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Robert C. Irwin MD</b>				29c. License number <b>D08900</b>		29d. Date signed (Month, Day, Year) <b>10-10-02</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert C. Irwin MD 828 N. Eutaw St. Baltimore MD 21201</b>									
31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>		32. Registrar's Signature <b>B. Sparks</b>							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32530

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Virgie Josephine Ruppert

2. Date of Death

Month Day Year  
Oct. 12, 2000

3. Time of Death

3:30 pm

4a. Facility Name (If not institution, give street and number)

Paradise Asst. Living

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

216-56-9069

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 20, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Pikesville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4731 Old Court Rd.

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Robert Kessler Specht

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Brengle

19a. Informant's Name/Relationship (Type, Print)

Diane Carol Ruppert - Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

43 Cedarhill Rd., Randallstown, Md. 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Olive Ch. Cem. Oct. 14, 2000

Date

20c. Location - City or Town, State

Randallstown, Md.

21. Signature of Funeral Service Licensee

H. G. Ehrhardt

22. Name and Address of Facility

Eckhardt Funeral Chapel  
11605 Reisterstown Rd., Owings Mills, Md. 2111723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Congestive heart failure.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Assisted living.

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Alyamma J. Mathew M.D.

29c. License number

D 27716

29d. Date signed (Month, Day, Year)

10/13/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Alyamma J. Mathew 5411 9d Frederick Rd Baltimore MD 21229.

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 16 2000

32. Registrar's Signature

Alyamma J. Mathew

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28e-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32531

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Saunders

2. Date of Death

Month

Day

Year

3. Time of Death

10-12 2000 06:30 pm

4a. Facility Name (If not institution, give street and number)

Bon Secour

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

238-24-6039

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

5-10-13

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2601 ROSLYN AVENUE

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

UNKNOWN

16b. Kind of Business/Industry UNKNOWN

17. Father's Name (First, Middle, Last) UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname) UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

Celia Ramson / Legal Guardian

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

34 Market Place Suite 300 Baltimore, MD 21202

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

10-14-00

20c. Location - City or Town, State

Londonderry, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WYLIE FUNERAL HOME CA. 435 N. GILMORE ST. BALTIMORE MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic bowel disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Intestinal obstruction

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

upper gastro intestinal bleeding

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D18327

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

moges Gebremariam 4660 Wilkens Ave Balto 21229

31. Date filed (Month, Day, Year)

32. Registrar's Signature

OCT 16 2000

[Signature]

State  
Registrar

ORIGINAL

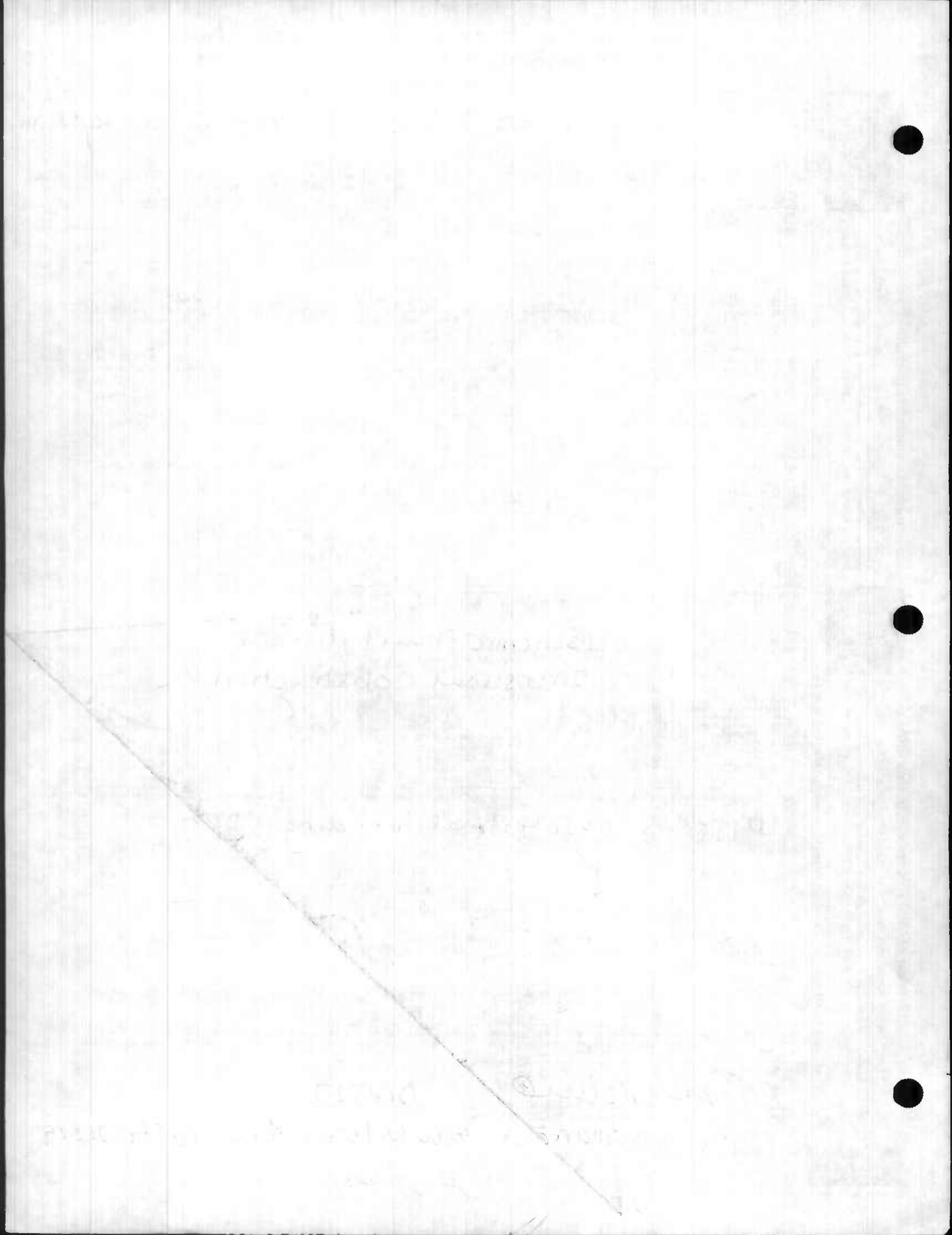
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32532

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GEORGE D. SMITH JR.</b>				2. Date of Death Month Day Year <b>October 08, 2000</b>		3. Time of Death <b>11:10 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>219-40-5324</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>46</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 20, 1954</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>31 N. Kossuth St.</b>		10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>U.S.A</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>CITY</b>		17. Father's Name (First, Middle, Last) <b>GEORGE D. SMITH</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>ROSALIE ROUZER</b>		19a. Informant's Name/Relationship (Type, Print) <b>ROSALIE A. SMITH</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>31 N. Kossuth St. Balt. MD. 21229</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>M.T. Zion</b>		20c. Location - City or Town, State <b>Longview, Md.</b>		20d. Date <b>10/4/00</b>		21. Signature of Funeral Service Licensee <b>GARY P. ARCHER</b>	
	22. Name and Address of Facility <b>270 FREDERICK PASS BALT. MD. 21229</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>SEIZURE DISORDER</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> D.O.A. Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Dennis J. Chute, MD</b>	
	29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>October 09, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J. Chute, MD</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>		31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>	
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <b>Benita S. Sparks</b>		33. State Registrar <b>OCT 16 2000</b>		34. State Registrar <b>OCT 16 2000</b>		35. State Registrar <b>OCT 16 2000</b>	

ORIGINAL



Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>ANNIE CREDELIA SCOTT</b>		2. Date of Death Month Day Year <b>OCTOBER 10 2000</b>		3. Time of Death <b>11:08 A</b>	
4a. Facility Name (If not institution, give street and number) <b>1102 DRUID HILL AVE</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>214-20-7298</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>SEPT 2, 1925</b>		9. Birthplace (State or Foreign Country) <b>SOUTH CAROLINA</b>			
10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>1602 DRUID HILL AVENUE</b>		10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2 YRS</b> College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ENUMERATION CLERK SOCIAL SECURITY</b>	
16b. Kind of Business/Industry		17. Father's Name (First, Middle, Last) <b>SAMUEL JONES</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MARIE LEWIS</b>	
19a. Informant's Name/Relationship (Type, Print) <b>MARLENE BOWIE (SISTER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15 CHARLES PLAZA APT. #305 BALTO. MD. 21201</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY 10-14-00 LANSDOWNE, MARYLAND</b>		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD. 21217</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Hypertensive Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>10-14-00</b>		28b. Time of Injury <b>M</b>	
28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 	
29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>OCTOBER 11, 2000</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>JACK M. TINS, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>	
31. Data filed (Month, Day, Year) <b>OCT 16 2000</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32534

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FREDERICK BAUER SISSON</b>				2. Date of Death Month Day Year <b>October 10, 2000</b>		3. Time of Death <b>4:30 pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>				4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>214-34-3792</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>68</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>02-16-1932</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent								
10a. State <b>MD.</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BOWLEYS QUARTERS</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. Street and Number <b>820 COLDSRING ROAD</b>				10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1952-1954</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4 YEARS</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>OWNER AND OPERATOR</b>			16b. Kind of Business/Industry <b>FLORIST</b>		
17. Father's Name (First, Middle, Last) <b>EDWARD B. SISSON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARGARET C. BAUER</b>					
19a. Informant's Name/Relationship (Type, Print) <b>ERNESTINE I. SISSON (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>820 COLDSRING RD., BOWLEYS QUARTERS, MD. 21220</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>EMTOMBMENT GARDENS OF FAITH</b>			Date <b>10-14</b>		20c. Location - City or Town, State <b>BALTIMORE, MD. 21206</b>		
21. Signature of Funeral Service Licensee <b>R. H. Luth</b>				22. Name and Address of Facility <b>HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>PULMONARY EDEMA</b> Due to (or as a consequence of):  b. <b>CONGESTION AND CONSOLIDATION, SEVERE</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death  <b>1-WEEK</b>  <b>WEEKS</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>Laranya Yarlagadda</b>				29c. License number <b>RD203406</b>			29d. Date signed (Month, Day, Year) <b>10-10-00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR Laranya Yarlagadda 9000 Franklin Square Drive Baltimore MD 21237</b>									
31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>		32. Registrar's Signature <b>B. Sparks</b>							

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32535

AMEND#4A&amp;10E PER F.H. G788 10-31-2000 JAB

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NANCY WICKES SHAW</b>				2. Date of Death Month Day Year <b>OCT. 09 2000</b>		3. Time of Death <b>10:45PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>8415 1845 BELLONA LANE</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>216-46-3325</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>NOV. 15 1913</b>		9. Birthplace (State or Foreign Country) <b>MD.</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>TOWSON</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>8415 1845 BELLONA LANE</b>				10f. Zip Code <b>21204</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE</b>			16b. Kind of Business/Industry <b>HOMEMAKER</b>	
17. Father's Name (First, Middle, Last) <b>WALTER F. WICKES</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CATHERINE YOUNG</b>				
19a. Informant's Name/Relationship (Type, Print) <b>JOHN K. SHAW III (SON)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3737 BUTLER RD. GLYNDON, MD. 21071.</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREEN MOUNT CREMATORY</b>			Date <b>10/11/2000</b>		20c. Location - City or Town, State <b>BALTO., MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HENRY W. JENKINS &amp; SONS CO. 4905 YORK RD. BALTO., MD. 21212</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): b. <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death <b>HRS.</b> <b>WEEKS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D0007697</b>		29d. Date signed (Month, Day, Year) <b>OCT 11, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARCIO M. MENENDEZ M.D. 923 ROLANDVUE RD. TOWSON, MD. 21204.</b>								
31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 2025.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32536

Amended ITEM 3 8 per FHG788 10/17/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jean Parker Stricker</b>				2. Date of Death Month Day Year <b>October 14, 2000</b>		3. Time of Death <b>4:30 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>1425 Dalewood Drive</b>				4b. City, Town, or Location of Death <b>Jarrettsville</b>		4c. County of Death <b>Harford Co.</b>	
Funeral Director	5. Social Security Number <b>220-14-3496</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB 7 1923</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Harford Co.</b>		10c. City, Town or Location <b>Jarrettsville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <b>1425 Dalewood Drive</b>			
	10f. Zip Code <b>21084</b>				10g. Citizen of What Country? <b>United States</b>			
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Accounting</b>		16b. Kind of Business/Industry <b>Hospital</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Milton Katzenberger</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Etta Parker</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Joseph M. Stricker /Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1425 Dalewood Drive Jarrettsville, MD 21084</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Mary's Govans Cem.</b>		20c. Date <b>10/17/00</b>		20d. Location - City or Town, State <b>Baltimore, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>Michael E. Canapp</b>		22. Name and Address of Facility <b>5305 Harford Road LEONARD J. RUCK, INC. Baltimore, MD 21214</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Metastatic Pancreatic Carcinoma</b>							Approximate Interval Between Onset and Death
	Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred							
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <b>Richard L. Huslig MD</b>		29c. License number <b>D36814</b>		29d. Date signed (Month, Day, Year) <b>10/14/00</b>			
	30. Name and address of person who completed cause of death after 23a) (Type, Print) <b>Richard L. Huslig MD 7505 OSUR DR. SUITE 303 Towson MD</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>		32. Registrar's Signature <b>[Signature]</b>					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32537

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Christine A Smith</i>				2. Date of Death Month <i>October</i> Day <i>15</i> Year <i>2000</i>		3. Time of Death <i>12:04pm</i>	
	4a. Facility Name (If not institution, give street and number) <i>Northwest Hospital Center</i>				4b. City, Town, or Location of Death <i>Randallstown</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>215-58-0257</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <i>49</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Jan. 2, 1951</i>	
	10a. State <i>MD</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Reisterstown</i>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Sales person</i>		16b. Kind of Business/Industry <i>Health &amp; Beauty</i>	
	17. Father's Name (First, Middle, Last) <i>Fred C. Zolonas</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Florence Gorski</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Fred C. Zolonas Father</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>12 Juliet Lane, Apt. 102, Baltimore, MD 21236</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Garden of Faith</i>		20c. Location - City or Town, State <i>10/18/00 Baltimore, MD</i>	
Physician /Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Eline Funeral Home 11824 Reisterstown Road Reisterstown, MD 21136</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Cardiac Arrhythmia</i> Due to (or as a consequence of): <i>b. Acute pancreatitis</i> Due to (or as a consequence of): <i>c. Alcoholism</i> Due to (or as a consequence of): <i>d. Morbid obesity</i>							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature] MD</i>		29c. License number <i>D46263</i>	
	29d. Date signed (Month, Day, Year) <i>October 15 2000</i>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>A. YOUSSEFI MD NWHC 5401 Old Court Road MD 21133</i>			
	31. Date filed (Month, Day, Year) <i>OCT 16 2000</i>				32. Registrar's Signature <i>[Signature]</i>			

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32538

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) **Leanna Mary Stanton** 2. Date of Death Month **October** Day **11** Year **2000** 3. Time of Death **4:50 PM**

Funeral  
Director

4a. Facility Name (If not institution, give street and number) **Franklin Square Hospital Center** 4b. City, Town, or Location of Death **Rosedale** 4c. County of Death **Baltimore**

5. Social Security Number **215-03-4327** 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) **83** Yrs. If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) **March 11, 1917** 9. Birthplace (State or Foreign Country) **Maryland**

Usual Residence of Decedent

10a. State **Md.** 10b. County **Baltimore** 10c. City, Town or Location **Perry Hall** 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number **104 Jumper Circle** 10f. Zip Code **21236** 10g. Citizen of What Country? **U.S.A.**

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: **White**

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) **8** College (1-4 or 5+) **Housewife** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Homemaker** 16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last) **Harry Keen** 18. Mother's Name (First, Middle, Maiden Summa) **Eula Milburn**

19a. Informant's Name/Relationship (Type, Print) **Leslie Stanton - Husband** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **104 Jumper Circle, Perry Hall, Md. 21236**

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) **Lake View Mem. Park Oct. 14, 2000** Date **2000** 20c. Location - City or Town, State **Sykesville, Md.**

21. Signature of Funeral Service Licensee **H. J. Schladt** 22. Name and Address of Facility **Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117**

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **a. Acute Cerebrovascular Accident** Due to (or as a consequence of): **b. Hypertension** Due to (or as a consequence of): **c.** Due to (or as a consequence of): **d.** Approximately Interval Between Onset and Death **2 Days**

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last **Arteriosclerotic Cardiovascular Disease, Diabetes Mellitus** **Coronary Artery Disease** **Coronary Artery Bypass Graft**

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **Arteriosclerotic Cardiovascular Disease, Diabetes Mellitus** 23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury **M** 28c. Injury at Work? ☐ Yes ☒ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier **Marco Zamora MD** 29c. License number **D40819** 29d. Date signed (Month, Day, Year) **October 11, 2000**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Marco Zamora MD, 9000 Franklin Square Drive Baltimore Maryland 21237**

31. Date filed (Month, Day, Year) **OCT 16 2000** 32. Registrar's Signature **[Signature]**

State  
Registrar

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Laboratory Station

212-02-1227

and 11, 1119

Barry Bell

2120

104 Street Circle

State

Housewife

Barry Bell

Barry Bell - 1119

1119 Street Circle, Barry Bell, 2120

John W. Bell, 1119 Street Circle, 2120

1119 Street Circle, Barry Bell, 2120

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32539

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>IRENE AMELIA STEARNS</b>				2. Date of Death Month Day Year <b>October 10, 2000</b>		3. Time of Death <b>1:35pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Greater Baltimore Medical Center</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>215-24-5973</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 14, 1909</b>	
	9. Birthplace (State or Foreign Country) <b>Nova Scotia</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore County</b>		10c. City, Town or Location <b>Anneslie</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <b>715 Dunkirk Road</b>		10f. Zip Code <b>21212</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Own Residence</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>George Gates</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Genevieve Walters</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mr. William Stearns (Husband)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>715 Dunkirk Road, Baltimore, Maryland 21212</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Cemetery</b>			
	20c. Location - City or Town, State <b>Baltimore, Maryland</b>				20d. Date <b>10/16/2000</b>			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Robert M. Kratz</b>				22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>emphysema</b> Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>years</b>			
To Be Completed by Physician/Medical Examiner	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>congestive heart failure</b> <b>nitral regurgitation</b> <b>asthma</b>				23c. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	23d. Describe how injury occurred				23e. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) <b>M</b>			
	28b. Time of Injury <b>M</b>				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				28g. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Bruce Rosenberg</b>			
	29c. License number <b>D24121</b>				29d. Date signed (Month, Day, Year) <b>10/10/00</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BRUCE ROSENBERG 21 WEST RD TOWSON, MD 21204</b>				31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>			
	32. Registrar's Signature <b>B. Sparks</b>				33. Registrar's Signature <b>B. Sparks</b>			

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 31 PER D.V.R. G788 10-16-00 WR.

## Certificate of Death

Reg. No.

00 32540

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

HELENTRUST

2. Date of Death  
Month Day Year

OCTOBER 12 2000

3. Time of Death

12:04 PM

4a. Facility Name (If not institution, give street and number)

Riverview Care Center

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

215076308

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

08/12/08

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

ESSEX

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13A GLENWOOD ROAD

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

CLERK

16b. Kind of Business/Industry

OFFICE BUS.

17. Father's Name (First, Middle, Last)

CHARLES HRDLICKA

18. Mother's Name (First, Middle, Maiden Surname)

MARIE KOZLOVSKY

19a. Informant's Name/Relationship (Type, Print)

MARIE E. SCHROETER/NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6719 UNIVERSITY DR. BALTIMORE, MD 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLY REDEEMER

Date

10/16/00

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CVACH/ROSEDALE FUNERAL HOME  
1211 CHESACO AVE BALTIMORE, MD 21237

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Coronary Vascular Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Lower gastrointestinal bleed. with perforated viscus.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D19667

29d. Date signed (Month, Day, Year)

10-14-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL H. SCHWARTZ 5517 -A RITCHE HIGHWAY BALTIMORE, MD 21225

31. Date filed (Month, Day, Year)

OCT 16 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



RECEIVED






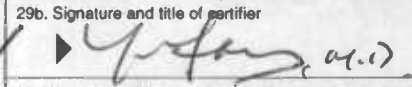

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32541

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RUTH A. YOUNG</b>				2. Date of Death Month Day Year <b>OCTOBER 8, 2000</b>		3. Time of Death <b>10:02am</b>	
	4a. Facility Name (If not institution, give street and number) <b>1501 KENHILL AVE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>215-22-6668</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>02-07-25</b>		9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1501 KENHILL AVE</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MACHINE OPERATOR</b>			16b. Kind of Business/Industry <b>MANUFACTURING</b>	
17. Father's Name (First, Middle, Last) <b>DALLAS WESTON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ANNE ELIZABETH STASIL</b>				
19a. Informant's Name/Relationship (Type, Print) <b>JOANN JOHNSON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>409 JEFFERSON AVE, TOWSON MD 21286</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBITUS MEMORIAL PK</b>		20c. Location - City or Town, State <b>10-12-00 MARYLAND</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO., MD 21207</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>Metastatic Breast Cancer</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number <b>D0054582</b>		29d. Date signed (Month, Day, Year) <b>10/13/00</b>
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>YIPING YAN, M.D. 401 North Broadway, Baltimore, MD 21231</b>								
31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32542

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>JOSEPH H. ZIMMERMAN</b>		2. Date of Death Month <b>OCT</b> Day <b>11</b> Year <b>2000</b>		3. Time of Death <b>6:30 PM</b>							
4a. Facility Name (If not institution, give street and number) <b>HOPKINS Bayview Hospital</b>		4b. City, Town, or Location of Death <b>BALTO.</b>		4c. County of Death <b>N/A</b>							
5. Social Security Number <b>213-30-7483</b>	6. Sex <b>M</b> <input type="checkbox"/> F <input type="checkbox"/>	7. Age (In yrs. last birthday) <b>66</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>AUG 5, 1934</b>	9. Birthplace (State or Foreign Country) <b>MD</b>							
Usual Residence of Decedent											
10a. State <b>MD.</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
10e. Street and Number <b>939 S. CLINTON ST.</b>		10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>USA</b>							
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:							
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>									
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MECHANICAL ENGINEER</b>		16b. Kind of Business/Industry <b>MANUFACTORY</b>									
17. Father's Name (First, Middle, Last) <b>WILLIAM M. ZIMMERMAN</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MARGARET SCHODER KNOBLING</b>									
19a. Informant's Name/Relationship (Type, Print) <b>JANE PERASH (sister)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1944 ROSEPOINTE WAY SPRING GROVE PA-17362</b>									
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BAYVIEW CREMATORY</b>		20c. Location - City or Town, State <b>BALTO. MD.</b>							
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>DELLA NOLAS SONS FUNERAL HOME 322 S. HIGH ST. BALTO. MD. 21202</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
<table border="1"> <tr> <td>Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Heart Failure</b></td> <td rowspan="4">Approximate Interval Between Onset and Death <b>1 yr chronic</b></td> </tr> <tr> <td rowspan="4">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>b. Due to (or as a consequence of): <b>Ischemic Heart Disease</b></td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td>d. Due to (or as a consequence of):</td> </tr> </table>					Immediate Cause (Final disease or condition resulting in death)	a. <b>Heart Failure</b>	Approximate Interval Between Onset and Death <b>1 yr chronic</b>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): <b>Ischemic Heart Disease</b>	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)	a. <b>Heart Failure</b>	Approximate Interval Between Onset and Death <b>1 yr chronic</b>									
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): <b>Ischemic Heart Disease</b>										
	c. Due to (or as a consequence of):										
	d. Due to (or as a consequence of):										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier  <b>DUNCAN S. SALYER</b>		29c. License number <b>D25733</b>		29d. Date signed (Month, Day, Year) <b>10/16/00</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>5601 Loch Raven Blvd Baltimore MD 21239</b>											
31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>		32. Registrar's Signature 									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32543

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOAN VERONICA AGOLIA</b>				2. Date of Death Month Day Year <b>SEPT. 29, 2000</b>		3. Time of Death <b>10:40 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>4146 BLACK ROCK RD.</b>				4b. City, Town, or Location of Death <b>HAMPSTEAD</b>		4c. County of Death <b>Carroll</b>	
Funeral Director	5. Social Security Number <b>050-26-9342</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>12/6/1933</b>	
	9. Birthplace (State or Foreign Country) <b>NEW YORK</b>		10a. State <b>MD</b>		10b. County <b>CARROLL</b>		10c. City, Town or Location <b>HAMPSTEAD</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>4146 BLACK ROCK RD.</b>		10f. Zip Code <b>21074</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SECRETARY</b>		16b. Kind of Business/Industry <b>MANUFACTURING</b>			
	17. Father's Name (First, Middle, Last) <b>FRED BARONE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>VERONICA PETTY</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>DONNA KUHN - DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4146 BLACK ROCK RD., HAMPSTEAD, MD. 21074</b>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		20c. Location - City or Town, State <b>9/30/00 BALTIMORE, MD.</b>		21. Signature of Funeral Service Licensee 	
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility <b>FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Multiple Sclerosis</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death <b>15 years</b>			
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier 				29c. License number <b>D33281</b>		29d. Date signed (Month, Day, Year) <b>9/29/00</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PAUL FORST MD 912 Washington Rd. Westminster, MD 21157</b>				31. Date filed (Month, Day, Year) <b>OCT 02 2000</b>			
	32. Registrar's Signature 				33. Date of Death <b>SEPT. 29, 2000</b>			

1871



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32544

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Alex Ayers

2. Date of Death

September 27, 2000

3. Time of Death

12:15 PM

4a. Facility Name (If not institution, give street and number)

1621 Schucks Road

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

220-24-6208

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 17, 1928

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1621 Schucks Road

10f. Zip Code

21015

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Animal Research

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Chester Bulley Ayers

18. Mother's Name (First, Middle, Maiden Surname)

Anis (u/k) Jennings

19a. Informant's Name/Relationship (Type, Print)

Jeanette M. Ayers / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1621 Schucks Road, Bel Air, Maryland 21015

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion U.M. Cemetery

Date

9-29-00

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Colon Cancer with metastasis

Approximate Interval Between Onset and Death

2 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Systemic Lupus Erythematosus

75 years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0016389

29d. Date signed (Month, Day, Year)

September 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PERFECTO C. VALARAO, M.D. 1716 HARTFORD RD SU. 106 FALLSTON MD 21047

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 1 - 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

BH

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32545

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Lee ALSTON				2. Date of Death Month Day Year September 15, 2000		3. Time of Death 9:50 PM	
	4a. Facility Name (If not institution, give street and number) Garrett County Memorial Hospital				4b. City, Town, or Location of Death Oakland		4c. County of Death Garrett	
Funeral Director	5. Social Security Number 251-44-0105	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 3, 1929		9. Birthplace (State or Foreign Country) South Carolina
	Usual Residence of Decedent							
10a. State MD		10b. County Garrett		10c. City, Town or Location Oakland		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number Cuppert-Weeks Nursing Home				10f. Zip Code 21550		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Home		
17. Father's Name (First, Middle, Last) Sam ----- Wade				18. Mother's Name (First, Middle, Maiden Surname) Mary Alice McDowell				
19a. Informant's Name/Relationship (Type, Print) Shiela W. Kneeshaw/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2474 Iroquis, Detroit, Michigan 48214				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Russell Cemetery		20c. Location - City or Town, State 9/21/00 Winnsboro, SC		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, MD 21550				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Pneumonia Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):								Approximate Interval Between Onset and Death Days
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D23979		29d. Date signed (Month, Day, Year) 9/16/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert Goralski, MD 311 N. Fourth St., Oakland, Maryland 21550								
31. Date filed (Month, Day, Year) SEP 18 2000				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32546

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ronnie Everett ARNOLD, Sr.				2. Date of Death Month Day Year September 22, 2000		3. Time of Death 3:15 PM		
	4a. Facility Name (If not institution, give street and number) 28 Apache Trail				4b. City, Town, or Location of Death Oakland		4c. County of Death Garrett		
Funeral Director	5. Social Security Number 234-78-8612		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 50 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 23, 1949		
	9. Birthplace (State or Foreign Country) West Virginia		10a. State MD		10b. County Garrett		10c. City, Town or Location Oakland		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 28 Apache Trail		10f. Zip Code 21550		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: VietNam		13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 <sup>nd</sup> th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Produce Manager		16b. Kind of Business/Industry Grocery Store		17. Father's Name (First, Middle, Last) Darl Everett Arnold		
	18. Mother's Name (First, Middle, Maiden Surname) Margaret Alice Pine		19a. Informant's Name/Relationship (Type, Print) Sharon S. Arnold/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Apache Trail, Oakland, Maryland 21550		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Accident Cemetery		20c. Date 10/25/00		20d. Location - City or Town, State Horseshoe Run, WV		21. Signature of Funeral Service Licensee 		
	22. Name and Address of Facility Stewart Funeral Home 32 S. Second St., Oakland, MD 21550		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. sarcoidosis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death years		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		
	29c. License number D15333		29d. Date signed (Month, Day, Year) 9/23/00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Thomas Johnson, MD 311 N. Fourth St., Oakland, Maryland 21550		31. Data filed (Month, Day, Year) SEP 26 2000		
32. Registrar's Signature 		33. State Registrar SEP 26 2000		34. State Registrar SEP 26 2000		35. State Registrar SEP 26 2000		36. State Registrar SEP 26 2000	

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32547

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ernest Thomas Adams, Jr.

2. Date of Death  
Month Day Year  
September 24, 20003. Time of Death  
7:00 PM

4a. Facility Name (If not institution, give street and number)

19071 Flat Iron Road

4b. City, Town, or Location of Death

Valley Lee

4c. County of Death

St. Mary's

Funeral  
Director

5. Social Security Number

217-36-9277

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 29, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Valley Lee

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19071 Flat Iron Road

10f. Zip Code

20692

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Farm

17. Father's Name (First, Middle, Last)

Ernest Thomas Adams, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Henrietta Booth

19a. Informant's Name/Relationship (Type, Print)

Louise E. Adams (Spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

General Delivery, Drayden, Maryland 20630

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. George's Catholic Cemetery

Date

9/27/2000

20c. Location - City or Town, State

Valley Lee, Maryland

21. Signature of Funeral Service Licensee

Michael L. Gardiner

22. Name and Address of Facility

Matingley-Gardiner Funeral Home, P.A.  
P.O. Box 270, Leonardtown, Maryland 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

seconds

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James C. Byrd, MD

29c. License number

D19917

29d. Date signed (Month, Day, Year)

9/26/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James C. Byrd, MD

California, Maryland 20619

31. Date filed (Month, Day, Year)

SEP 27 2000

32. Registrar's Signature

James C. Byrd

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32548

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anna Mae Aud</b>				2. Date of Death Month <b>September</b> Day <b>25</b> Year <b>2000</b>		3. Time of Death <b>1:10 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>20697 Chingville Road</b>				4b. City, Town, or Location of Death <b>Leonardtown</b>		4c. County of Death <b>St. Mary's</b>	
Funeral Director	5. Social Security Number <b>216-22-3476</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>72</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 20, 1928</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>Leonardtown</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>20697 Chingville Road</b>		10f. Zip Code <b>20650</b>		
10g. Citizen of What Country? <b>United States</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Payroll Supervisor</b>		16b. Kind of Business/Industry <b>US Government</b>		
17. Father's Name (First, Middle, Last) <b>Anthony DeSales Delozier</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nettie Elizabeth Cullison</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Benedict I. Aud / Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20697 Chingville Road, Leonardtown, Maryland 20650</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Face Cemetery</b>		20c. Date <b>9-28-00</b>		20d. Location - City or Town, State <b>Great Mills, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Mary B. Rizzo</b> Mary B. Rizzo M01114		22. Name and Address of Facility <b>Brinsfield Funeral Home, P.A.</b> <b>22955 Hollywood Road, Leonardtown, MD 20650-0279</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>a. Pulmonary Failure</b> Due to (or as a consequence of): <b>b. Carcinomatosis</b> Due to (or as a consequence of): <b>c. Lung Cancer</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>wk</b> <b>months</b> <b>1 yr.</b>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>James Patrick Jarboe</b>		29c. License number <b>D06417</b>		29d. Date signed (Month, Day, Year) <b>9-26-00</b>		
30. Name and address of person who completed Cause of death (Item 23e) (Type, Print) <b>J. Patrick Jarboe, M.D., 24035 Three Notch Road, Hollywood, Maryland 20636</b>								
31. Date filed (Month, Day, Year) <b>SEP 27 2000</b>		32. Registrar's Signature <b>B. Sparks</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32549

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Catherine Marie Abell				2. Date of Death Month Day Year September 15, 2000				3. Time of Death 10:55 PM	
	4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center				4b. City, Town, or Location of Death Leonardtown				4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 219-72-2500		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) March 19, 1913		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Hollywood				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 23915 Lawrence Hayden Road				10f. Zip Code 20636		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) James Greenwell				18. Mother's Name (First, Middle, Maiden Surname) Phoebe Harding					
	19a. Informant's Name/Relationship (Type, Print) Mary E. Brugman (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23915 Lawrence Hayden Road, Hollywood, Maryland 20636					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. John's Catholic Cemetery		Date 9/20/2000		20c. Location - City or Town, State Hollywood, Maryland			
	21. Signature of Funeral Service Licensee Michael K. Gardiner		22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of): a. Cardiopulmonary Arrest b. General Debility and Dehydration c. Advanced Dementia (Senile Dementia) d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 2 months	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Rheumatoid Arthritis Hypoalbuminemia								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Kae T. Aung, MD		29c. License number D051738		29d. Date signed (Month, Day, Year) 9-18-00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kae T. Aung, MD Hollywood, Maryland 20636										
31. Date filed (Month, Day, Year) SEP 19 2000		32. Registrar's Signature B. A. Smith								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Item 29c, per Phy.

State of Maryland / Department of Health and Mental Hygiene

00 32550

10/02/2000, Carroll County, wjl

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Edwin Beall</u>			2. Date of Death Month <u>September</u> Day <u>25</u> Year <u>2000</u>			3. Time of Death <u>9:30 AM</u>							
	4a. Facility Name (If not institution, give street and number) <u>University of Maryland Medical Systems</u>			4b. City, Town, or Location of Death <u>Baltimore</u>			4c. County of Death <u>Baltimore City</u>							
Funeral Director	5. Social Security Number <u>115-09-0944</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>82</u> Yrs.		8. Date of Birth Month <u>Jan.</u> Day <u>17</u> Year <u>1918</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>					
	10a. State <u>MD</u>			10b. County <u>Carroll</u>			10c. City, Town or Location <u>Sykesville</u>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <u>6309 Candlewick Court</u>			10f. Zip Code <u>21784</u>			10g. Citizen of What Country? <u>USA</u>								
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <u>WWII</u>			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>White</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u></u>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Administrator</u>			16b. Kind of Business/Industry <u>Telephone</u>								
17. Father's Name (First, Middle, Last) <u>Edward Beall</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Cora R. Beall</u>											
19a. Intomant's Name/Relationship (Type, Print) <u>Mrs. Pauline A. Beall (Wife)</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6309 Candlewick Court Sykesville, MD 21784</u>											
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>All County Cremation Srv.</u>			20c. Location - City or Town, State <u>9/26/00 Sykesville, MD</u>								
21. Signature of Funeral Service Licensee <u>Brian L. Hays</u>			22. Name and Address of Facility <u>HAIGHT FUNERAL HOME &amp; CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400</u>											
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			a. <u>Acute Blood loss from Gastrointestinal Tract</u> Due to (or as a consequence of):			b. <u>BRAIN MASS</u> Due to (or as a consequence of):			c. Due to (or as a consequence of):				
	d. Due to (or as a consequence of):			Approximate Interval Between Onset and Death <u>1 DAY</u>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown											
			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)			28b. Time of Injury <u>M</u>			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier <u>Jorge Uribe</u>			29c. License number <u>P14654</u>			29d. Date signed (Month, Day, Year) <u>September 26, 2000</u>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Jorge Uribe 22 South Greene Street, Baltimore, Maryland 21201</u>														
State Registrar	31. Date filed (Month, Day, Year) <u>OCT 02 2000</u>			32. Registrar's Signature <u>Beverly B Sparks</u>										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32551

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH

BARNES

2. Date of Death

Month Day Year  
SEPTEMBER 28, 2000

3. Time of Death

2:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

CARROLL COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

WESTMINSTER

4c. County of Death

CARROLL

5. Social Security Number

217-07-8711

6. Sex

☐ M ☒ F

7. Age (in yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
2/24/1913

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

CARROLL

10c. City, Town or Location

WESTMINSTER

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

111 SMITH AVE.

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

TELEPHONE OPERATOR

16b. Kind of Business/Industry

TELEPHONE CO.

17. Father's Name (First, Middle, Last)

GEORGE A. E. HITCHCOCK

18. Mother's Name (First, Middle, Maiden Surname)

CLARA VIRGINIA LANTZ

19a. Informant's Name/Relationship (Type, Print)

GERALDINE B. RECK-DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

111 SMITH AVE., WESTMINSTER, MD. 21157

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

WESTMINSTER CEMETERY

Date

10/1/00

20c. Location - City or Town, State

WESTMINSTER, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility FLETCHER FUNERAL HOME

254 E. MAIN ST., WESTMINSTER, MD. 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Anoxic Encephalopathy

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Acute MYOCARDIAL INFARCTION

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending

Investigation

☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

DS1245

29d. Date signed (Month, Day, Year)

SEPTEMBER 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SASID SHARIF CARROLL COUNTY GENERAL HOSPITAL - MD

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 02 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Barnes, Elizabeth Hannah  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32552

Physician  
(Medical  
Examiner)

1. Decedent's Name (First, Middle, Last)

ANNA E. BOND

2. Date of Death

Month

Day

Year

September 29 2000

3. Time of Death

530A

4a. Facility Name (If not Institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

219-30-3696

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 8, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Harford

10c. City, Town or Location

Abingdon

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

246 Kensington Parkway

10f. Zip Code

21009

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Clothing Industry

17. Father's Name (First, Middle, Last)

Joseph Rynes

18. Mother's Name (First, Middle, Maiden Surname)

Antonia Bores

19a. Informant's Name/Relationship (Type, Print)

Joan T. Godbee (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

246 Kensington Parkway, Abingdon, MD 21009

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer Cem.

Date

10/2/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.  
610 W. MacPhail Road, Bel Air, MD 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Colon Cancer

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

DS3462

29d. Date signed (Month, Day, Year)

9/29/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jude Munese 7845 Oakwood Road Glen Burnie, MD 21061

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 3 - 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
(Medical  
Examiner)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Bx. Bond Anna





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32553

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen Sunday Bagwell</b>		2. Date of Death Month <b>September</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>1425</b>
	4a. Facility Name (If not institution, give street and number) <b>Harford Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Havre de Grace</b>		4c. County of Death <b>Harford</b>
Funeral Director	5. Social Security Number <b>203-09-9582</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Oct. 25, 1910</b>		9. Birthplace (State or Foreign Country) <b>New Jersey</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>46 Smith Avenue</b>		10f. Zip Code <b>21001</b>	
10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Billing</b>		16b. Kind of Business/Industry <b>Telephone Company</b>			
17. Father's Name (First, Middle, Last) <b>Jacob Sunday</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Straughan</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Joan B. Zentrick (Daughter)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>46 Smith Ave., Aberdeen, Maryland 21001</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baker Cemetery</b>		20c. Location - City or Town, State <b>10/3/00 Aberdeen, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Kirsten Amy Unglesbee</b>		22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>CVA</b>  Due to (or as a consequence of): <b>urosepsis, CHF</b>  Due to (or as a consequence of): <b>myelodysplastic syndrome</b>  Due to (or as a consequence of): <b>malnutrition</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>chronic atrial fibrillation</b>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <b>Brian T. Yeo, MD</b>		29c. License number <b>D15152</b>		29d. Date signed (Month, Day, Year) <b>9/29/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Brian T. Yeo, MD 501 S. Union Ave, Havre de Grace, MD 21076</b>					
31. Date filed (Month, Day, Year) <b>OCT 1 - 2000</b>		32. Registrar's Signature <b>B. Spade</b>			

001 - 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend # 23b 9.28.00

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death HCHD

Reg. No.

00-32554

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Avis Edeline Bennett				2. Date of Death Month Day Year September 27, 2000				3. Time of Death 6:00 AM	
	4a. Facility Name (If not institution, give street and number) 3738 Federal Lane				4b. City, Town, or Location of Death Abingdon				4c. County of Death Harford	
Funeral Director	5. Social Security Number 491-01-4406		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 11, 1913		9. Birthplace (State or Foreign Country) Missouri	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Harford		10c. City, Town or Location Abingdon				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 3738 Federal Lane				10f. Zip Code 21009		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Jesse Edmund Smith				18. Mother's Name (First, Middle, Maiden Surname) Flossie Dell Ferguson					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Judy K. Hughes / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3738 Federal Lane, Abingdon, MD 21009					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ozark Memorial		Date 9-30-00		20c. Location - City or Town, State Joplin, Missouri			
	21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Renal FAILURE</u> Due to (or as a consequence of): b. <u>Hypertension</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>PARKINSON'S DISEASE</u>									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier [Signature] MD.				29c. License number D0053536		29d. Date signed (Month, Day, Year) 9/27/00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL GOLDSMITH MD 1321 RIVERSIDE PKWY Belcamp MD 21017									
31. Date filed (Month, Day, Year) SEP 28 2000										
32. Registrar's Signature [Signature]										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32555

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANTOINETTE LOUISE BONGARDT

2. Date of Death

Month Day Year  
Sept. 24, 2000

3. Time of Death

5:45 a.m.

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215-30-6638

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 19, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

10 Lockhart Circle, Apt. F

10f. Zip Code

21050

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Casimier Novak

18. Mother's Name (First, Middle, Maiden Surname)

Anna Caster

19a. Informant's Name/Relationship (Type, Print)

Robert G. Bongardt (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 Lockhart Circle, Apt. F, Forest Hill, MD 21050

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Sacred Heart of Mary Cem 9/27/00 Dundalk, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.  
610 W. MacPhail Road, Bel Air, MD 2101423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) HOSPICE

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D43725

29d. Date signed (Month, Day, Year)

9/26/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

[Signature]

SEPTEMBER 24, 2000 5:45 a.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

ANTOINETTE BONGARDT

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit.





Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DONALD REESE BAKER				2. Date of Death Month Day Year August 31, 2000				3. Time of Death 7:20 A.M.	
	4a. Facility Name (If not institution, give street and number) 32970 Roy West Road				4b. City, Town, or Location of Death Delmar				4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 222-22-1339		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 62 Yrs.		8. Date of Birth (Month, Day, Year) APR 30, 1938		9. Birthplace (State or Foreign Country) DELAWARE	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County WICOMICO		10c. City, Town or Location DELMAR				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 32970 ROY WEST ROAD				10f. Zip Code 21875		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1956-59		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CARPENTER			16b. Kind of Business/Industry CONSTRUCTION		
	17. Father's Name (First, Middle, Last) REESE MARVIL BAKER				18. Mother's Name (First, Middle, Maiden Surname) VERA JOSEPH					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) CINDY L. REID / DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RT. 1 BOX 209, LITTLE LANE, DELMAR, DE 19940					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CAPITOL CREMATORY SERV.		Data 9/2/00		20c. Location - City or Town, State DOVER, DELAWARE			
	21. Signature of Funeral Service Licensee Richard T. Watson				22. Name and Address of Facility WATSON FUNERAL HOME, INC. 211 WASHINGTON ST., MILLSBORO, DELAWARE 19966					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. COMPRESSIONAL ASPHYXIA ASSOCIATED WITH ACUTE ETHANOL INTOXICATION Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE									
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined									
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year)									
	28b. Time of Injury M									
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	28d. Describe how injury occurred									
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier Dennis Chute				29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) SEPTEMBER 01, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis Chute 111 Penn Street, Baltimore, Maryland 21201									
	31. Date filed (Month, Day, Year) OCT 16 2000									
State Registrar	32. Registrar's Signature B. Sparks									



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32557

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KERMIT RICHARD BROADWATER</b>				2. Date of Death Month Day Year <b>SEPT. 12, 2000</b>				3. Time of Death <b>0805 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>292 NORTH PARK ROAD</b>				4b. City, Town, or Location of Death <b>GRANTSVILLE</b>				4c. County of Death <b>GARRETT</b>	
Funeral Director	5. Social Security Number <b>218-22-4108</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b>		8. Date of Birth (Month, Day, Year) <b>FEB 5, 1926</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>---</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>1719 HOLLINS STREET</b>				10f. Zip Code <b>21223</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW 2</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11 th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FORKLIFT OPERATOR</b>				16b. Kind of Business/Industry <b>MANUFACTURING</b>		
17. Father's Name (First, Middle, Last) <b>NEVIN ULYSSES BROADWATER</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>MYRTLE ESTELLE GLOTFELTY</b>					
19a. Informant's Name/Relationship (Type, Print) <b>RONALD L. BROADWATER/NEPHEW</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>312 NORTH PARK RD., BOX 93, GRANTSVILLE, MD 21536</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GRANTSVILLE CEM.</b>			20c. Date <b>SEPT 16, 2000</b>		20d. Location - City or Town, State <b>GRANTSVILLE, MD</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>NEWMAN FUNERAL HOMES, P.A., PO BOX 275 179 MILLER ST. GRANTSVILLE, MD 21536</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Contact Gunshot wound of head</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <b>Limited</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>9-11-2000</b>		28b. Time of Injury <b>2345 M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>subject shot self</b>		
28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) <b>yard</b>					28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>292 N. Park Road Garrett County, Maryland</b>					
29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 					29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>SEPT. 13, 2000</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>SEP 18 2000</b>					32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at 202.5.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32558

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Ford Bowes

2. Date of Death

September 21, 2000

3. Time of Death

4:00 a.m.

4a. Facility Name (If not institution, give street and number)

17785 Clarke Road

4b. City, Town, or Location of Death

Tall Timbers

4c. County of Death

St. Mary's

Funeral  
Director

5. Social Security Number

579-01-4028

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 20, 1913

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Valley Lee

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

44780 Tall Timbers Road

10f. Zip Code

20692

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Book store owner

16b. Kind of Business/Industry

Self employed-  
Retail book store

17. Father's Name (First, Middle, Last)

John Ford Bowes

18. Mother's Name (First, Middle, Maiden Surname)

Anna Mae Mattern

19a. Informant's Name/Relationship (Type, Print)

John F. Bowes,

Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 126, Compton, Maryland 20627

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Francis Xavier

Date

9-25-00

20c. Location - City or Town, State

Leonardtown, Maryland

21. Signature of Funeral Service Licensee

Edward N. Brinsfield, Jr. M00052

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.

22955 Hollywood Road, Leonardtown, MD 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CARCINOMA OF THE LUNG

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

YRS.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Son's Residence

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D14285

29d. Date signed (Month, Day, Year)

9-22-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William D. Boyd II, M.D., 25365 Point Lookout Road, Leonardtown, Maryland 20650

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

P. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Christopher Lee Bell</b>				2. Date of Death Month Day Year <b>SEPTEMBER 17, 2000</b>		3. Time of Death <b>1630 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>PT. LOOKOUT STATE PARK</b>				4b. City, Town, or Location of Death <b>PT. LOOKOUT</b>		4c. County of Death <b>ST. MARY'S</b>		
Funeral Director	5. Social Security Number <b>546-41-0523</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>25 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 6, 1975</b>			
	9. Birthplace (State or Foreign Country) <b>California</b>		Usual Residence of Decedent						
10a. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>California</b>			10d. Inside City Limits <b>1 Yes 2 No</b>		
10e. Street and Number <b>22545 Joan Drive</b>				10f. Zip Code <b>20619</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <b>1 Never Married 2 Married</b> <b>3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Food Manager</b>		16b. Kind of Business/Industry <b>Frozen Food</b>			
17. Father's Name (First, Middle, Last) <b>Unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jane Louise Bell</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Jane L. Bell McHugh Mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15310 Point Lookout Road, St. Inigoes, Maryland 20684</b>					
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State</b> <b>4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Brinsfield-Echols crematory</b>		20c. Location - City or Town, State <b>9-21-00 Charlotte Hall, Maryland</b>					
21. Signature of Funeral Service Licensee <b>Edward N. Brinsfield, Jr. M00052</b>				22. Name and Address of Facility <b>Brinsfield Funeral Home, P.A. 20650</b> <b>22955 Hollywood Road, Leonardtown, Maryland</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Drowning</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>									
24a. Was an autopsy performed? <b>1 Yes 2 No</b>									
24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>									
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE</b>							
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide</b> <b>5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year) <b>9/17/00 (FOUND)</b>		28b. Time of Injury (Hour, Min) <b>1410 M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>			
28d. Describe how injury occurred <b>Subject Drowned in River</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>River</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>St. Mary's County, Md.</b>					
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>		29b. Signature and title of certifier <b>Joseph Pestaner, M.D.</b>		29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 18, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>SEP 22 2000</b>		32. Registrar's Signature <b>Bruce S. Sparks</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32560

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Benjamin Beavan, Sr.				2. Date of Death Month Day Year SEPTEMBER 15 2000				3. Time of Death 7:55AM	
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital				4b. City, Town, or Location of Death Leonardtown				4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 212-24-4358		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) September 27, 1923		9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Chaptico	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 24790 Hurry Road		10f. Zip Code 20621		10g. Citizen of What Country? U.S.A.		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer	
	16b. Kind of Business/Industry Farm		17. Father's Name (First, Middle, Last) Bernard Stanton Beavan, Sr.		18. Mother's Name (First, Middle, Maiden Surname) Lillian Catherine Mattingly		19a. Informant's Name/Relationship (Type, Print) Agnes Marie Beavan (Spouse)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24790 Hurry Road, Chaptico, Maryland 20621	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Queen of Peace Cemetery		20c. Location - City or Town, State Helen, Maryland		21. Signature of Funeral Service Licensee <i>Michael K. Gardiner</i>		22. Name and Address of Facility Mattingly-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650	
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <u>Chronic Myelocytic Leukemia</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>William D. Boyd II M.D.</i>		29c. License number D14285		29d. Date signed (Month, Day, Year) 9-15-00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM D. BOYD II M.D. LEONARDTOWN, MD. 20650		31. Date filed (Month, Day, Year) SEP 15 2000		32. Registrar's Signature <i>B. Sparks</i>					

SEP 12 2008

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32561

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Stacy Denise Blair				2. Date of Death Month: AUGUST Day: 30 Year: 2000		3. Time of Death 17:06
	4a. Facility Name (If not institution, give street and number) OLD VILLAGE ROAD AND FLORA CORNER ROAD				4b. City, Town, or Location of Death MECHANICSVILLE		4c. County of Death ST. MARY'S
Funeral Director	5. Social Security Number 219-04-9103	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 16 Yrs.	8. Date of Birth (Month, Day, Year) December 24, 1983	9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County St. Mary's	10c. City, Town or Location Mechanicsville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 41369 Riverview Road			10f. Zip Code 20659		10g. Citizen of What Country? U S A	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student		16b. Kind of Business/Industry High School	
	17. Father's Name (First, Middle, Last) Marvin Frederick Blair				18. Mother's Name (First, Middle, Maiden Surname) Yvonne Elizabeth Hensley		
	19a. Informant's Name/Relationship (Type, Print) Yvonne E. Blair (Mother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41369 Riverview Road, Mechanicsville, Maryland 20659		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Evergreen Cemetery		20c. Date 9/5/00	20d. Location - City or Town, State Erwin, Tennessee	
	21. Signature of Funeral Service Licensee <i>Michael Gardiner</i>				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>Multiple Injuries</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):						
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 8/30/00		28b. Time of Injury 1706 M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET		28d. Describe how injury occurred Driver in auto accident Old Village Rd / Flora Corner Rd					
29a. Certifier Check only 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Deborah Locke</i>				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) AUGUST 31, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. LAFON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201							
State Registrar	31. Date filed (Month, Day, Year) SEP 06 2000		32. Registrar's Signature <i>B. Sparks</i>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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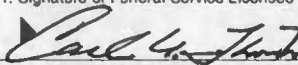
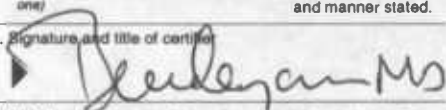
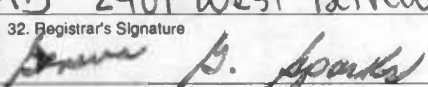
State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #23 PART I, 28A-F PER MEO 6788 10-6-00 WR.

Reg. No.

00 32562

## Certificate of Death

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>AGNES WISE PARKER BULL</b>				2. Date of Death Month Day Year <b>August 17 2000</b>		3. Time of Death <b>0610</b>
	4a. Facility Name (If not institution, give street and number) <b>Sinai Hospital of Baltimore</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>231-28-2580</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>AUG. 5, 1928</b>	9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>VIRGINIA</b>	10b. County <b>ACCOMACK</b>	10c. City, Town or Location <b>OAK HALL</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>8066 LANKFORD HWY.</b>			10f. Zip Code <b>23416</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>3</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BOOKKEEPER</b>		16b. Kind of Business/Industry <b>ACCOUNTING/FINANCIAL</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>AUGUSTIN BOYKIN PARKER</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>MARY MARGARET WEBB</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>KITTY SUE BULL ROSE</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 1474 - OCEANVIEW, DE 19970</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WESSELLS CEMETERY</b>		Date <b>8/20/00</b>		20c. Location - City or Town, State <b>MEARS, VA</b>
	21. Signature of Funeral Service Licensee  <b>CARL THORNTON</b>		22. Name and Address of Facility <b>THORNTON FUNERAL HOME 24183 CHADBOURNE ST. - PARKSLEY, VA 23421</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>AGONAL ASPIRATION</b> <b>ASPIRATION</b> Due to (or as a consequence of): <b>Chronic obstructive pulmonary disease.</b> Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>ENDOMETRIAL CANCER</b>						Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ENDOMETRIAL CANCER</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
State Registrar	29b. Signature and title of certifier  <b>Jose Bendayan MD</b>			29c. License number <b>RES: 000</b>		29d. Date signed (Month, Day, Year) <b>August 17, 2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOSE BENDAYAN, MD 2401 West Belvidere Ave Baltimore Md. 21215</b>						
31. Date filed (Month, Day, Year) <b>AUG 24 2000</b>		32. Registrar's Signature 					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32563

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sarah E. Christy				2. Date of Death Month Day Year September 29, 2000				3. Time of Death 5:55 AM		
	4a. Facility Name (If not institution, give street and number) CITIZENS Nursing Home				4b. City, Town, or Location of Death Havre de Grace				4c. County of Death Harford		
Funeral Director	5. Social Security Number 215-32-2237		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) Jun. 6, 1909		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent				10a. State Maryland				10b. County Harford		10c. City, Town or Location Havre de Grace
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 415 Market Street				10f. Zip Code 21078		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housekeeper				16b. Kind of Business/Industry Domestic			
17. Father's Name (First, Middle, Last) Samuel Giles				18. Mother's Name (First, Middle, Maiden Surname) Florence Green							
19a. Informant's Name/Relationship (Type, Print) Mary Woodson / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 138 Vancherie Ct., Havre de Grace, MD 21078							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Union United Meth. Cemetery				20c. Location - City or Town, State Aberdeen, Maryland		20d. Date 10/3/00	
21. Signature of Funeral Service Licensee Lisa Scott				22. Name and Address of Facility Lisa M. Scott Funeral Services 552 Lewis Street, Havre de Grace, MD 21078							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cerebrovascular Accident Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death within Few Hours	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Parkinson's Disease										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier M. Sparks				29c. License number D19583				29d. Date signed (Month, Day, Year) September 29, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANUEL N. LAZARIN MD 8 Law Street Aberdeen, Maryland 21001											
31. Date filed (Month, Day, Year) OCT 1 - 2000				32. Registrar's Signature M. Sparks							



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State of Maryland / Department of Health and Mental Hygiene

00 32564

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edmund Philip Crivello, Sr.</b>				2. Date of Death Month <b>September</b> Day <b>24</b> Year <b>2000</b>				3. Time of Death <b>2:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>91 Jumpers Circle</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>218-14-5390</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>May 17, 1923</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>91 Jumpers Circle</b>		10f. Zip Code <b>21236</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12th Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Systems Analyst</b>		16b. Kind of Business/Industry <b>Banking</b>		17. Father's Name (First, Middle, Last) <b>Gasparo Crivello</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Angelina Spaminato</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Virginia Crivello (wife)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>91 Jumpers Circle, Baltimore, MD 21236</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem.</b>		20c. Location - City or Town, State <b>9/27/00 Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Bruce A. Willett</b>		22. Name and Address of Facility <b>Schimunek Funeral Home, Inc.</b> <b>9705 Belair Rd., Baltimore, MD 21236</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Metastatic Renal cell carcinoma</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>7 months</b>  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		Approximate Interval Between Onset and Death				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>emphysema</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>Sept 25th, 2000</b>		28b. Time of Injury <b>M</b>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <b>Dr. J. J. Williams MD</b>		29c. License number <b>DH5530</b>		29d. Date signed (Month, Day, Year) <b>Sept 25th, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>6830, Suite 206, hospital drive, MD - 21237</b>		31. Date filed (Month, Day, Year) <b>SEP 26 2000</b>		32. Registrar's Signature <b>B. Spoth</b>						





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32565

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bertha Virginia Cox

2. Date of Death  
Month Day Year

Sept. 28 2000

3. Time of Death

2:40 am

4a. Facility Name (If not Institution, give street and number)

Lauralwood Nursing Home

4b. City, Town, or Location of Death

Elkton

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

219-12-6236

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Oct. 30, 1914

9. Birthplace (State or Foreign Country)

USA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Chesapeake City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2970 Augustine Herman Highway

10f. Zip Code

21915

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7yrs

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Thomas Hinson Bailey

18. Mother's Name (First, Middle, Maiden Surname)

Bertha Virginia Bailey

19a. Informant's Name/Relationship (Type, Print)

Joyce Ann Stansfield

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

241 Woods Rd. Elkton, Md. 21915

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Pauls Cemetery

Date

10/1/00

20c. Location - City or Town, State

Earlville, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein &amp; Newnam Funeral Home

226 E. Main St. Cecilton, Md. 21913

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Anemia  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

1 MONTH

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Unspecified Leukemia  
Due to (or as a consequence of):

1 MONTH

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Monte Makous, MD

29c. License number

D-44783

29d. Date signed (Month, Day, Year)

September 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MONTE MAKOUS, MD 111 WEST HIGH STREET, ELKTON, MD 21924

31. Date filed (Month, Day, Year)

OCT - 3 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

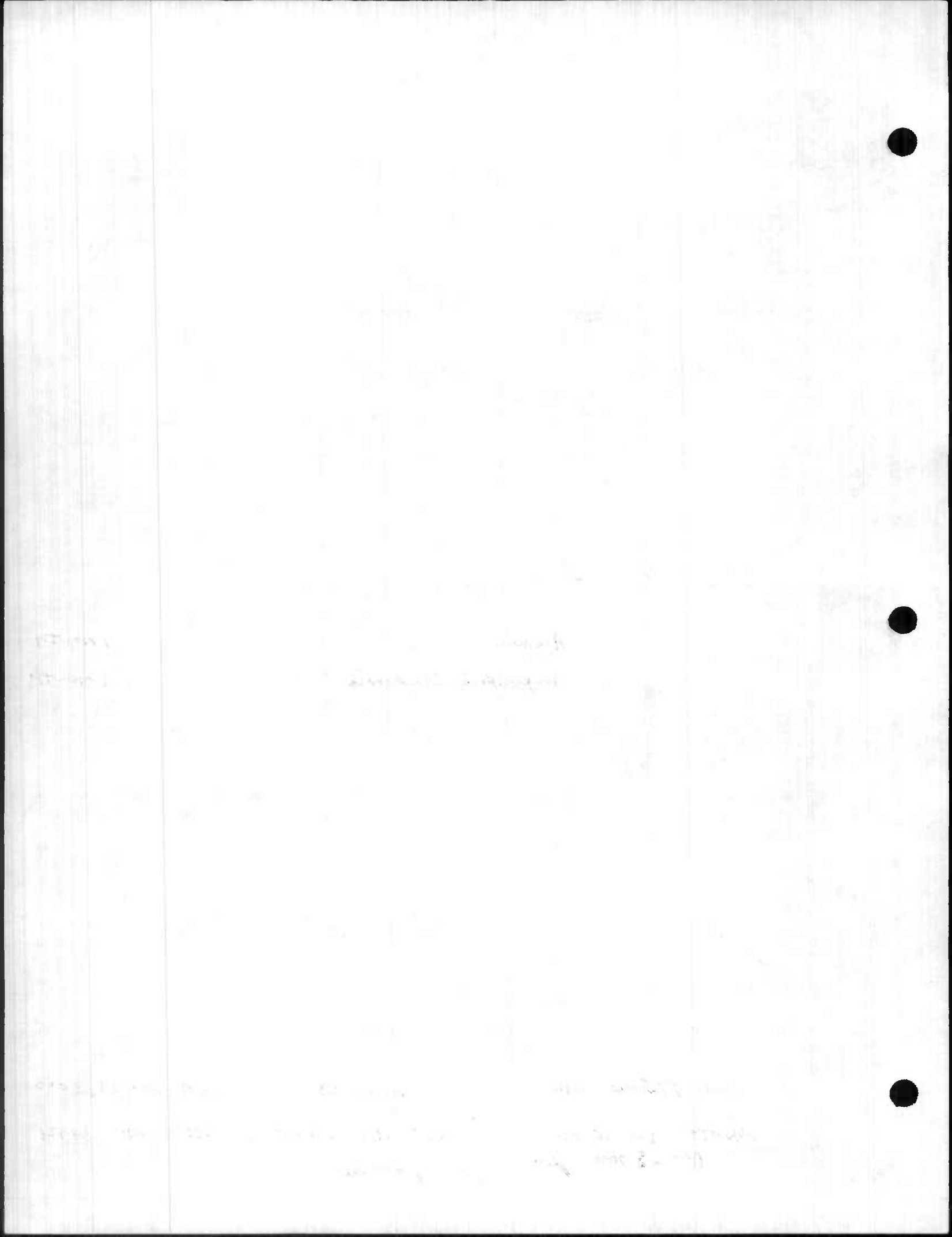
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32566

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lena Cook</b>		2. Date of Death Month <b>October</b> Day <b>4</b> Year <b>2000</b>		3. Time of Death <b>9:35pm</b>
	4a. Facility Name (If not institution, give street and number) <b>William Hill Manor</b>		4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>
Funeral Director	5. Social Security Number <b>215-16-6079</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>08/08/1911</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Talbot</b>		10c. City, Town or Location <b>Easton</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>501 Dutchmans Lane</b>		10f. Zip Code <b>21601</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>none</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner/Operator</b>		16b. Kind of Business/Industry <b>Restaurant</b>			
17. Father's Name (First, Middle, Last) <b>William Fleming</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Susie Bradley</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Charles T. Gordon/Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>111 Hamlet Hill Road, Baltimore, Md. 21210</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Beechwood Cemetery</b>		20c. Location - City or Town, State <b>10/7/00 Princess Anne, Md.</b>	
21. Signature of Funeral Service Licensee <b>James L. Hanna</b> M00295		22. Name and Address of Facility <b>Hinman Funeral Home</b> <b>11673 Somerset Ave., Princess Anne, Md. 21853</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Renal Failure</b> Due to (or as a consequence of): <b>b. Congestive Heart Failure</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>30</b> <b>2y</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D35284</b>	
29d. Date signed (Month, Day, Year) <b>10/5/00</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANDREA ALLEN 219 S Washington St Easton MD 21601</b>			
31. Date filed (Month, Day, Year) <b>OCT 06 2000</b>		32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

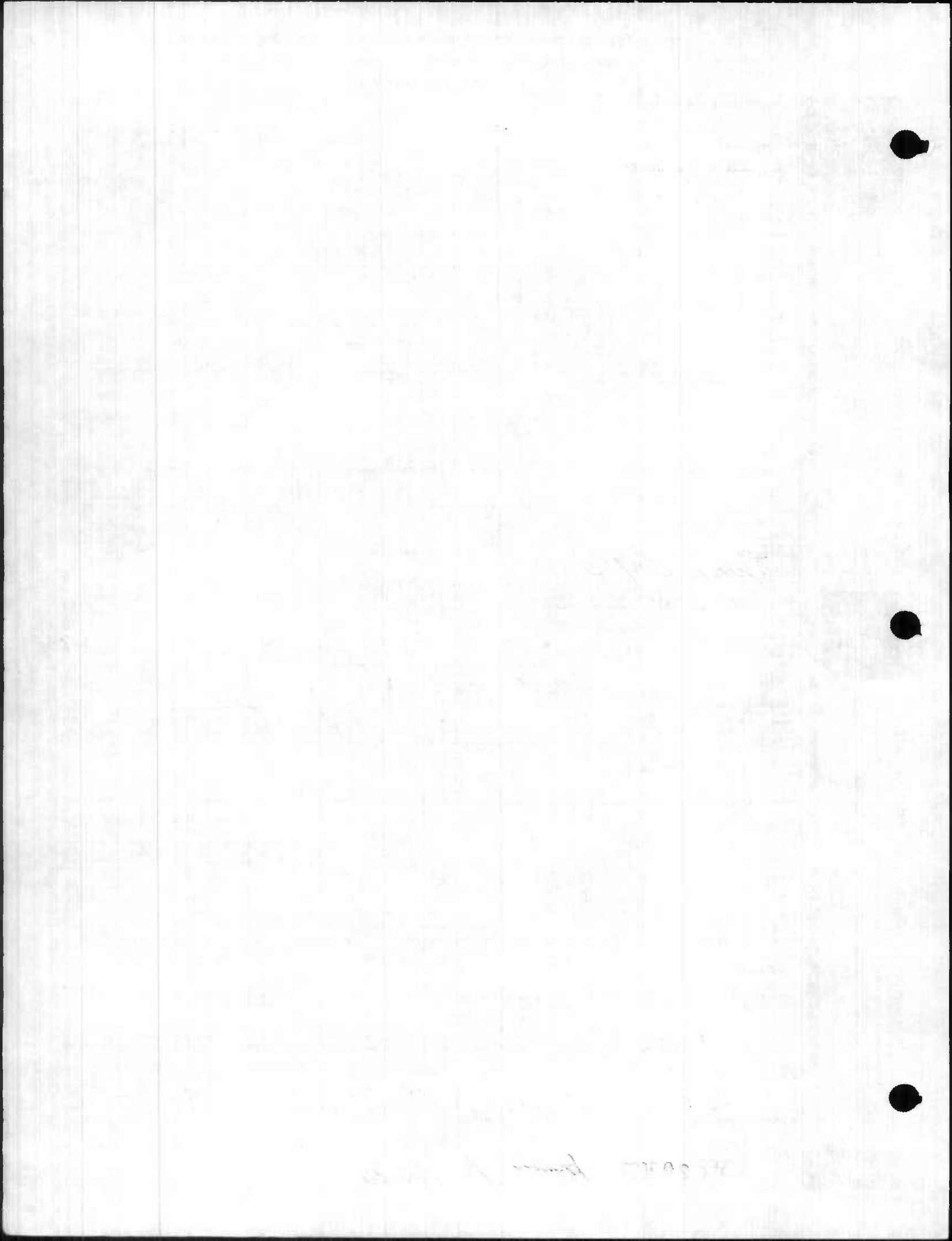
State of Maryland / Department of Health and Mental Hygiene

00 32567

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Herbert Vincent Cullison</b>				2. Date of Death Month Day Year <b>September 15, 2000</b>		3. Time of Death <b>9:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Bayside Care Center</b>				4b. City, Town, or Location of Death <b>Lexington Park</b>		4c. County of Death <b>St. Mary's</b>	
Funeral Director	5. Social Security Number <b>218-32-9290</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 30, 1933</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>Dameron</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>18690 St. Jerome's Neck Road</b>		10f. Zip Code <b>20628</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>--</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>		16b. Kind of Business/Industry <b>Auto</b>			
	17. Father's Name (First, Middle, Last) <b>Herbert S. Cullison</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Louise Wheatley</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Patricia A. Norris</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18901 Cully Lane, Lexington Park, MD 20653</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Brinsfield-Echols Crematory</b>		20c. Location - City or Town, State <b>9-18-00 Charlotte Hall, MD</b>			
	21. Signature of Funeral Service Licensee <b>Edward N. Brinsfield, Jr., M00052</b>				22. Name and Address of Facility <b>22955 Hollywood Road Brinsfield Funeral Home, P.A.</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiopulmonary failure</b> Due to (or as a consequence of): <b>b. Carcinomatosis</b> Due to (or as a consequence of): <b>c. Carcinoma of prostate</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>C.O.P.D.</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier <b>J. Patrick Jarboe M.D.</b>		29c. License number <b>D06419</b>		29d. Date signed (Month, Day, Year) <b>9-18-00</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Patrick Jarboe M.D. 24035 Three Notch Road, Hollywood, Maryland 20636</b>							
31. Date filed (Month, Day, Year) <b>SEP 20 2000</b>		32. Registrar's Signature <b>B. Sparks</b>						





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

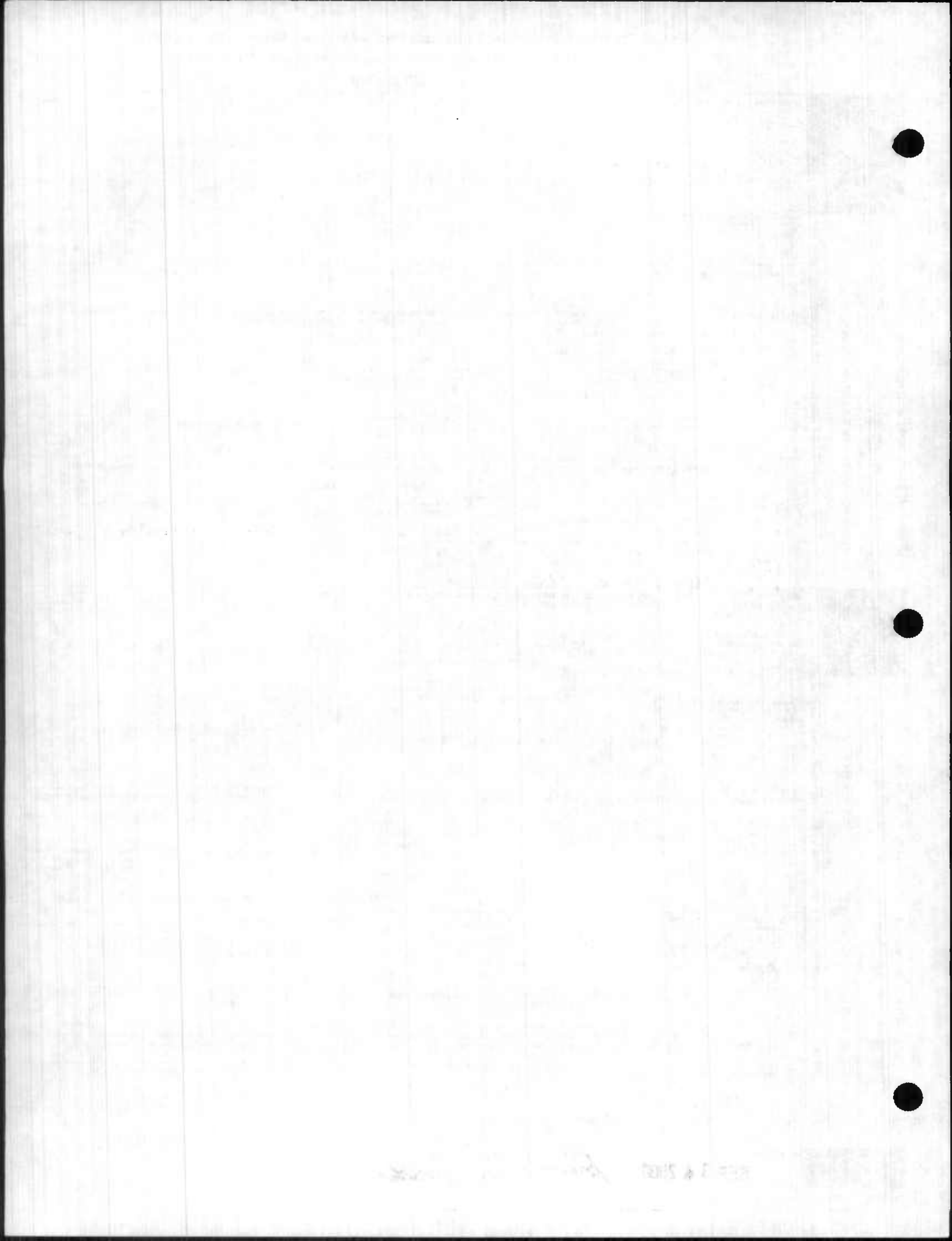
00 32568

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Cecelia Countis				2. Date of Death Month Day Year September 11, 2000				3. Time of Death 12:00 PM						
	4a. Facility Name (If not institution, give street and number) 21364 Cambridge Avenue				4b. City, Town, or Location of Death Lexington Park				4c. County of Death St. Mary's						
Funeral Director	5. Social Security Number 212-44-3339		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 54 Yrs.		8. Date of Birth (Month, Day, Year) March 2, 1946		9. Birthplace (State or Foreign Country) Maryland						
	Usual Residence of Decedent														
To Be Completed by Funeral Director	10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Lexington Park				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						
	10e. Street and Number 21364 Cambridge Avenue				10f. Zip Code 20653		10g. Citizen of What Country? U S A								
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) Collega (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cook			16b. Kind of Business/Industry Restaurant							
	17. Father's Name (First, Middle, Last) Joseph Ignatius Countiss				18. Mother's Name (First, Middle, Maiden Surname) Mary Ellen Curtis										
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Lisa M. Countis (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1311 Delaware Avenue, SW, Washington, DC 20024										
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Date 9/15/00		20d. Location - City or Town, State Alexandria, Virginia								
	21. Signature of Funeral Service Licensee Michael R. Gardiner				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ovarian Carcinoma Dua to (or as a consequence of): b. Dua to (or as a consequence of): c. Dua to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last														
	23b. Old tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred						
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier William K. Kelly, MD		29c. License number D39979		29d. Date signed (Month, Day, Year) 9/12/00
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William K. Kelly, MD. OPIS - St Mary's Hosp. Leonardtown MD										31. Date filed (Month, Day, Year) SEP 14 2000		32. Registrar's Signature [Signature]		

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32569

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Elizabeth Diffendal				2. Date of Death Month Day Year Sept 30 2000		3. Time of Death 6:35pm	
	4a. Facility Name (If not institution, give street and number) Summerville at Westminster				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 220-28-3922	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb 23 1906		9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent							
10a. State MD		10b. County Carroll		10c. City, Town or Location Westminster			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 14 Bond Street				10f. Zip Code 21157		10g. Citizen of What Country? USA		
11. Marital Status <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk			16b. Kind of Business/Industry Federal Government	
17. Father's Name (First, Middle, Last) Edward Oliver Diffendal				18. Mother's Name (First, Middle, Maiden Surname) Bessie Stoner				
19a. Informant's Name/Relationship (Type, Print) Rick Diffendal/Nephew				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Jasontown Rd Westminster, MD 21158				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Meadow Branch Cemetery 10/4 Westminster, MD		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>CVA</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death ~1 day
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>gastroenteritis</u>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) assisted living				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
				28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number D33576		29d. Date signed (Month, Day, Year) 10/3/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen J. Sikorski, M.D. 912 Washington Road Westminster, MD 21157								
31. Date filed (Month, Day, Year) OCT 03 2000				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-526-6000.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32570

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>Marlene Marie Dennis</b>						2. Date of Death Month Day Year <b>Oct. 01 2000</b>			3. Time of Death <b>6:50am</b>				
	4a. Facility Name (If not institution, give street and number) <b>101 Fairway Court</b>						4b. City, Town, or Location of Death <b>Havre de Grace</b>			4c. County of Death <b>Harford</b>				
<b>Funeral Director</b>	5. Social Security Number <b>003-26-7255</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <b>60</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>08/23/1940</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>	
	Usual Residence of Decedent													
10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Havre de Grace</b>						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
10e. Street and Number <b>101 Fairway Court</b>						10f. Zip Code <b>21078</b>			10g. Citizen of What Country? <b>USA</b>					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Retail</b>				16b. Kind of Business/Industry <b>Self-employed</b>				
17. Father's Name (First, Middle, Last) <b>William George Mezick</b>								18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Elizabeth Miller</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Leroy Dennis- Husband</b>								19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>101 Fairway Ct., Havre de Grace, MD 21078</b>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harford Memorial Grdns</b>				Date <b>10/5/00</b>		20c. Location - City or Town, State <b>Aberdeen, MD</b>				
21. Signature of Funeral Service Licensee <i>Quaine M. Smith</i>								22. Name and Address of Facility <b>Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death) a. <i>Squamous cell ca of lung</i> Due to (or as a consequence of):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> </div> </div>														
Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. <i>chronic obstructive pulmonary disease</i>										23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. Signature and title of certifier <i>Hung Sun Kim</i>								29c. License number <b>D37364</b>		29d. Date signed (Month, Day, Year) <b>October 3, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>19 Walnut Lane, Aberdeen, Maryland</i>														
31. Date filed (Month, Day, Year) <b>OCT 3 - 2000</b>						32. Registrar's Signature <i>B. Sparks</i>								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32571

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Annabelle Doerr</b>					2. Date of Death Month Day Year <b>September 27, 2000</b>			3. Time of Death <b>7:10 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Citizens Nursing Home</b>					4b. City, Town, or Location of Death <b>Havre de Grace</b>			4c. County of Death <b>Harford</b>		
Funeral Director	5. Social Security Number <b>212-18-0062</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>08/08/1919</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent					10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Havre de Grace</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					10e. Street and Number <b>145 Wilson St.</b>		10f. Zip Code <b>21078</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Home</b>			
17. Father's Name (First, Middle, Last) <b>Harold Hamilton</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Elliott</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Carol Blakeley- Niece</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>145 Wilson St., Havre de Grace, MD 21078</b>						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>R.A. Ferris &amp; Co. Inc.</b>			Date <b>9/28/00</b>		20c. Location - City or Town, State <b>West Chester, PA</b>			
21. Signature of Funeral Service Licensee <b>Gubine M. Smith</b>					22. Name and Address of Facility <b>Witchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>ALZHEIMER'S ds</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier <b>[Signature]</b>	
										29c. License number <b>D42800</b>	
										29d. Date signed (Month, Day, Year) <b>9/28/00</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>T. Biondo MD 319 S. Union Ave., H&amp;G, MD 21078</b>											
31. Date filed (Month, Day, Year) <b>SEP 28 2000</b>			32. Registrar's Signature <b>[Signature]</b>								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32572

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROGER LEVI DAWKINS				2. Date of Death Month Day Year September 20, 2000		3. Time of Death 4:38 pm	
	4e. Facility Name (If not institution, give street and number) University of Maryland Medical Systems				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 217-30-7585		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 67 Yrs.		8. Date of Birth (Month, Day, Year) JULY 5, 1933	
	9. Birthplace (State or Foreign Country) MARYLAND		10a. State MD		10b. County QUEEN ANNE'S		10c. City, Town or Location CENTREVILLE	
Usual Residence of Decedent								
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
10e. Street and Number 119 WATSON ROAD								
10f. Zip Code 21617								
10g. Citizen of What Country? USA								
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced								
12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1956-1958								
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:								
14. Race - American Indian, Black, White, etc. Specify: WHITE								
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11								
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HORSEMAN								
16b. Kind of Business/Industry EQUESTRIAN								
17. Father's Name (First, Middle, Last) ROGER WILLIAM DAWKINS								
18. Mother's Name (First, Middle, Maiden Surname) EVA CUMMINGS EVERETT								
19a. Informant's Name/Relationship (Type, Print) JANICE MOORE DAWKINS/ WIFE								
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 WATSON ROAD, CENTREVILLE, MD 21617								
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)								
20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CTR								
20c. Date 9-25-2000								
20d. Location - City or Town, State STEVENSVILLE, MD								
21. Signature of Funeral Service Licensed Thomas K. Helfenbein								
22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Organ System Failure Due to (or as a consequence of): Sepsis Renal Failure Respiratory Compromise Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Transplant								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined								
28a. Date of Injury (Month, Day, Year)								
28b. Time of Injury M								
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
28d. Describe how injury occurred								
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Christian Minshall								
29c. License number A0476435 M12445								
29d. Date signed (Month, Day, Year) September 22, 2000								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTIAN MINSHALL 22 South Greene Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) SEP 26 2000								
32. Registrar's Signature B. Sparks								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32573

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Earl Francis Dyson</b>				2. Date of Death Month Day Year <b>September 18, 2000</b>		3. Time of Death <b>7:35 p.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>St. Mary's Nursing Center</b>				4b. City, Town, or Location of Death <b>Leonardtwn</b>		4c. County of Death <b>St. Mary's</b>	
Funeral Director	5. Social Security Number <b>215-64-6014</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 1, 1912</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>Lexington Park</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>46475 Franklin Road</b>				10f. Zip Code <b>20653</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Farmer</b>			16b. Kind of Business/Industry <b>Agriculture</b>	
17. Father's Name (First, Middle, Last) <b>Phillip Briscoe Dyson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Frances Cleveland Downs</b>				
19a. Informant's Name/Relationship (Type, Print) <b>James Kenneth Dyson / Brother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8609 Saffron Drive, Lanham, Maryland 20706</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Immaculate Heart of Mary</b>		20c. Location - City or Town, State <b>9-20-00 Lexington Park, MD</b>		
21. Signature of Funeral Service Licensee <b>Edward N. Brinsfield, Jr. M00052</b>				22. Name and Address of Facility <b>Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Pneumonia</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>2 wks</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>congestive heart failure</b> <b>Atrial Fibrillation</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>						
		29c. License number <b>D19917</b>			29d. Date signed (Month, Day, Year) <b>9/20/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James C. Boyd, M.D., 23415 Three Notch Road, California, Maryland 20619</b>								
31. Date filed (Month, Day, Year) <b>SEP 20 2000</b>		32. Registrar's Signature <b>[Signature]</b>						

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32574

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William Dallas Davis, Sr.				2. Date of Death Month Day Year August 22, 2000		3. Time of Death 9:05 PM	
	4a. Facility Name (If not institution, give street and number) Charlotte Hall Veterans Home				4b. City, Town, or Location of Death Charlotte Hall		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 219-12-2875		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) August 9, 1918	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Hollywood	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 44430 Clarks Mill Road		10f. Zip Code 20636		10g. Citizen of What Country? U.S.A.	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 4th College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician		16b. Kind of Business/Industry U.S. Government			
	17. Father's Name (First, Middle, Last) Joseph King Davis				18. Mother's Name (First, Middle, Maiden Surname) Mary Adell Raley			
	19a. Informant's Name/Relationship (Type, Print) Grace Davis / Spouse				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 703, Hollywood, Maryland 20636			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Memorial Gardens		Date 8/25/00		20c. Location - City or Town, State Leonardtown, Maryland	
	21. Signature of Funeral Service Licensee <i>Richard Lewis Gardiner</i>				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (List only one cause on each line.) Colon Cancer				Approximate Interval Between Onset and Death			
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>J. Sees</i>				29c. License number D0052097		29d. Date signed (Month, Day, Year) 8/31/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janette Bell, 55 Stockley Rd Suite E Prince Frederick MD 20678								
31. Date filed (Month, Day, Year) SEP 06 2000		32. Registrar's Signature <i>G. Spawr</i>						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32575

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Elwood Enlow

2. Date of Death

Month Day Year  
September 24, 2000

3. Time of Death

11 p.m.

4a. Facility Name (If not institution, give street and number)

645 Milt DeWitt Road

4b. City, Town, or Location of Death

Friendsville

4c. County of Death

Garrett

Funeral  
Director

5. Social Security Number

338-18-3617

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan 4, 1925

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Friendsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

754 Milt DeWitt Road

10f. Zip Code

21531

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates: 1949-6913. Was Decedent of Hispanic Origin? (Specify Yes or No  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12 th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Farming

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

Lyman Sedwick Enlow

18. Mother's Name (First, Middle, Maiden Surname)

Helen Louise Hoyer

19a. Informant's Name/Relationship (Type, Print)

Paul H. Enlow/brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1267 Aiken-Miller Rd., Accident, MD 21520

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

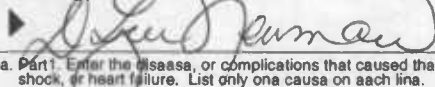
Sang Run Cem., Sept 27, 2000

Date

20c. Location - City or Town, State

McHenry, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Newman Funeral Homes, P.A., PO Box 275  
179 Miller St., Grantsville, MD 2153623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Pulmonary Fibrosis

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 year

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Cor pulmonale

Due to (or as a consequence of):

1 year

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus, Type II, Abscess right leg,

Deep venous thrombosis, Atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

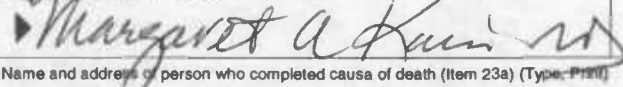
(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D26650

29d. Date signed (Month, Day, Year)

09/25/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Margaret A. Kaiser, M.D. 13079 Garrett Highway, Oakland, MD 21550

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 32576

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>MADELYN THOYTS FERGUSON</b>				2. Date of Death Month Day Year <b>OCT 4 2000</b>		3. Time of Death <b>9:14 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>	
5. Social Security Number <b>540-20-9402</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb 23, 1926</b>	
9. Birthplace (State or Foreign Country) <b>Oregon</b>							
Usual Residence of Decedent							
10a. State <b>VA</b>		10b. County <b>Fairfax</b>		10c. City, Town or Location <b>McLean</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>7018 Statendam Court</b>				10f. Zip Code <b>22101</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <b>I</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Eben Pomeroy</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Bethell</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Jackie Ferguson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7018 Statendam Court, McLean, VA 22101</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Potomac Crematory</b>		Date <b>10/9/00</b>		20c. Location - City or Town, State <b>Dale City, VA</b>	
21. Signature of Funeral Service Licensee  CC0387				22. Name and Address of Facility <b>A Dignified Funeral &amp; Cremation Service, Inc. 18401 Cedar Drive Triangle, VA 22172</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. AORTIC OCCLUSION WITH SEVERE CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 				29c. License number <b>D-3036 (TX)</b>		29d. Date signed (Month, Day, Year) <b>10-5-00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GARY D. KETRONE CDR, MC, USN</b>				<b>NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600</b>			
31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>				32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Michael Charles Ford

amend item 23a,27,28a,b,c,d,e,f per me G788 10/17/00 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32577

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) Michael Charles Ford		2. Date of Death Month Day Year October 07 2000		3. Time of Death 11:19 P.M.	
4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center		4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
5. Social Security Number 217-58-4456	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 49 Yrs.	8. Date of Birth (Month, Day, Year) March 25, 1951	9. Birthplace (State or Foreign Country) South Dakota	
Usual Residence of Decedent					
10a. State Maryland	10b. County Anne Arundel	10c. City, Town or Location Annapolis		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 300 A Forbes Street		10f. Zip Code 21401		10g. Citizen of What Country? United States	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Roofers	
17. Father's Name (First, Middle, Last) George W. Ford		18. Mother's Name (First, Middle, Maiden Surname) Marian Newton			
19a. Informant's Name/Relationship (Type, Print) Marian Ford / Mother		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 A Forbes St. Annapolis, MD 21401			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Ft. Lincoln Crematory		20c. Location - City or Town, State 10/10/00 Brentwood, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401			
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <u>NARCOTIC AND ALCOHOL INTOXICATION</u> Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. _____ Due to (or as a consequence of):			
		c. _____ Due to (or as a consequence of):			
		d. _____			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 10/7/00		28b. Time of Injury unknown M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unknown		28e. Location (Street and Number or Rural Route Number, City or Town, State) 300 A Forbes St., Annapolis, Md	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) October 9, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACK M. TRAVIS, M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) OCT 11 2000		32. Registrar's Signature 			

State  
Registrar

2000 10 10

0005 1 1 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32578

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen Julia Fleissner</b>				2. Date of Death Month Day Year <b>September 23, 2000</b>		3. Time of Death <b>8:50 AM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>29923 Crosswoods Drive</b>				4b. City, Town, or Location of Death <b>Mechanicsville</b>		4c. County of Death <b>St. Mary's</b>	
Funeral Director	5. Social Security Number <b>201-01-7288</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>January 18, 1912</b>	
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>Mechanicsville</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>29923 Crosswoods Drive</b>		10f. Zip Code <b>20659</b>		10g. Citizen of What Country? <b>U S A</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Freight Agent</b>		16b. Kind of Business/Industry <b>Railroad</b>		15. Decedent's Education (Specify only highest grade completed) <b>Collega (1-4or 5+)</b>		
17. Father's Name (First, Middle, Last) <b>Mike Zidik</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Onderick</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Frank McDonough (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14608 Wharf Road, Accokeek, Maryland 20607</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Immaculate Heart of Mary Cemetery</b>		20c. Date <b>9/26/2000</b>		20d. Location - City or Town, State <b>Lexington Park, Maryland</b>		
21. Signature of Funeral Service Licenses <i>Michael R. Gardiner</i>				22. Name and Address of Facility <b>Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Cerebro-vascular CVA</b>  Due to (or as a consequence of): <b>ALZheimer's dis</b>  Due to (or as a consequence of): <b>Cor. Insufficiency</b>  Due to (or as a consequence of): <b>Cor. Insufficiency</b>		Approximate Interval Between Onset and Death <b>15 YRS</b> <b>THW</b> <b>Insan</b>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and Title of certifier <i>Vinod K. Shah</i>						
		29c. License number <b>D 15032</b>		29d. Date signed (Month, Day, Year) <b>9/26/00</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Vinod K. Shah, MD</b>		31. Date filed (Month, Day, Year) <b>SEP 27 2000</b>						
		32. Registrar's Signature <i>B. Sparks</i>						

ORIGINAL

1005 8 3 732

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32579

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Everett Farrell			2. Date of Death Month Day Year September 14, 2000		3. Time of Death 7:15 PM	
	4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center			4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 220-16-4321	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 78	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 23, 1922	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State Maryland	10b. County St. Mary's	10c. City, Town or Location Bushwood		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 22844 Maddox Road			10f. Zip Code 20618		10g. Citizen of What Country? U S A	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) _____		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist		16b. Kind of Business/Industry Civil Service		
	17. Father's Name (First, Middle, Last) William Johnson Farrell			18. Mother's Name (First, Middle, Maiden Surname) Martha Louise Graves			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Adele O. Farrell (Spouse)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22844 Maddox Road, Bushwood, Maryland 20618			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart Catholic Cemetery		20c. Location - City or Town, State Bushwood, Maryland		
	21. Signature of Funeral Service Licensee Michael K. Gardiner			22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. Respiratory Failure Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. CLL Due to (or as a consequence of): d. _____  Approximate Interval Between Onset and Death 4-5 days 6-7 days years						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alzheimer dementia HTN						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier V. Mossman-VanEnderburg, MD			29c. License number D 0034870		29d. Date signed (Month, Day, Year) 9-15-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 East 107B Street Circle, Bloomington, MD 55420 V. Mossman-VanEnderburg							
31. Date filed (Month, Day, Year) SEP 15 2000		32. Registrar's Signature B. Sparks					

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32580

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Beacie Farris		2. Date of Death Month Day Year August 29, 2000		3. Time of Death 2:56 PM
	4a. Facility Name (If not institution, give street and number) 45975 Fox Chase Drive Apt. 414		4b. City, Town, or Location of Death Great Mills		4c. County of Death St. Mary's
Funeral Director	5. Social Security Number 420-58-0467	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 56 Yrs.	8. Date of Birth (Month, Day, Year) February 28, 1944	9. Birthplace (State or Foreign Country) Alabama
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State Maryland	10b. County St. Mary's	10c. City, Town or Location Great Mills		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 45975 Fox Chase Drive Apt. 414		10f. Zip Code 20634		10g. Citizen of What Country? U.S.A.
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)		
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Timothy Farris		18. Mother's Name (First, Middle, Maiden Surname) Martha Bass		
	19a. Informant's Name/Relationship (Type, Print) Jacquelyn Fowler (Daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45802 N. Springsteen Court, California, MD 20619		
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria, Virginia
	21. Signature of Funeral Service Licensee <i>Richard Farris</i>		22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Respiratory Failure Due to (or as a consequence of):  Chronic Lung Disease Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Myocardial Infarction Diabetes Mellitus				
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>William Boyd, II</i>					
29c. License number D14285					
29d. Date signed (Month, Day, Year) 8-30-00					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Boyd, II, MD Leonardtown, Maryland 20650					
31. Date filed (Month, Day, Year) SEP 01 2000					
32. Registrar's Signature <i>B. Sparks</i>					

ORIGINAL

Handwritten signature or initials

11.02.19.473

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State of Maryland / Department of Health and Mental Hygiene

00 32581

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARGARET LOUISE GARNER</b>				2. Date of Death Month Day Year <b>Sept. 30 2000</b>		3. Time of Death <b>2340</b>		
	4a. Facility Name (If not institution, give street and number) <b>Westminster Nursing &amp; Convalescent Center</b>				4b. City, Town, or Location of Death <b>Westminster</b>		4c. County of Death <b>Carroll County</b>		
Funeral Director	5. Social Security Number <b>219-14-8101</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 14 1923</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Carroll County</b>		10c. City, Town or Location <b>Taneytown</b>		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>32 Fairgrounds Avenue</b>		10f. Zip Code <b>21787</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>		16b. Kind of Business/Industry <b>own home</b>		17. Father's Name (First, Middle, Last) <b>Oliver Lambert</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lola Haines</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Steven L. Garner / son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2725 Crouse Mill Road Taneytown, Maryland 21787</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Trinity Lutheran Cemetery</b>		20c. Location - City or Town, State <b>Taneytown, Maryland</b>	
21. Signature of Funeral Service Licensee <i>Alan C. Davis</i>		M01072		22. Name and Address of Facility <b>Skiles Funeral Home</b> <b>136 East Baltimore Street Taneytown, MD 21787</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Renal Failure</b> Due to (or as a consequence of): <b>b. Myocardial infarction</b> Due to (or as a consequence of): <b>c. UGI Bleed</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>4 yrs</b> <b>1 wk</b> <b>10 days</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b> <b>28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b> <b>28d. Describe how injury occurred</b> <b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>John W. Middleton</i>		29c. License number <b>D25443</b>		29d. Date signed (Month, Day, Year) <b>10/2/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John W. Middleton 688-c POOLE Rd Westminster MD</b>		31. Date filed (Month, Day, Year) <b>OCT 02 2000</b>		32. Registrar's Signature <i>B. Sparks</i>		51157			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10/1/10  
10/2/10  
10/3/10

10/4/10  
10/5/10  
10/6/10

10/7/10  
10/8/10  
10/9/10

10/10/10  
10/11/10  
10/12/10

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State of Maryland / Department of Health and Mental Hygiene

00 32582

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WADE E. GREASON</b>			2. Date of Death Month Day Year <b>SEPTEMBER 30 2000</b>			3. Time of Death <b>4:00 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>			4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>			4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>219-40-6416</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>56</b> Yrs.	If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth Month Day Year <b>NOV. 30, 1943</b>	9. Birthplace (State or Foreign) <b>Maryland</b>
	Usual Residence of Decedent								
10a. State <b>W. VA.</b>		10b. County <b>Mineral</b>		10c. City, Town or Location <b>Burlington</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. Street and Number <b>Route 1, Box 184A</b>				10f. Zip Code <b>26710</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th grade</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance Supervisor</b>			16b. Kind of Business/Industry <b>Sealant Company</b>		
17. Father's Name (First, Middle, Last) <b>Wade H. Greason</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Clara Cummins</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Lucille Greason (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Route 1, Box 184A, Burlington, W. VA. 26710</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Mem. Gardens</b>		Date <b>10/3/00</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Mark T. [Signature]</b>				22. Name and Address of Facility <b>Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD 21014</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC LUNG CANCER</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death <b>3 YEARS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>Dr. [Signature] MD</b>				29c. License number <b>P13597</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 30 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARTINS UGWU-DIKE 600 N. Wolfe St. Baltimore, MD 21205</b>									
31. Date filed (Month, Day, Year) <b>OCT 3 - 2000</b>				32. Registrar's Signature <b>[Signature]</b>					





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32583

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last) <b>Vincent Edmond Giovannetti, Sr.</b>		2. Date of Death Month <b>October</b> Day <b>3</b> Year <b>2000</b>		3. Time of Death <b>08:10AM</b>	
4a. Facility Name (If not Institution, give street and number) <b>6575 Dobbins Court</b>			4b. City, Town, or Location of Death <b>La Plata</b>		4c. County of Death <b>Charles</b>
5. Social Security Number <b>577-07-0210</b>		6. Sex <b>Male</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
8. Date of Birth (Month, Day, Year) <b>October 19, 1919</b>					
9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>					
10a. State <b>Maryland</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>La Plata</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>6575 Dobbins Court</b>			10f. Zip Code <b>20646</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>USMC</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+) <b>-</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Oil Burner Technician</b>		16b. Kind of Business/Industry <b>Heating</b>
17. Father's Name (First, Middle, Last) <b>Edmond Giovannetti, Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth E. Palmer</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Sandy Murray/Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6575 Dobbins Court, La Plata, Md. 20646</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans Cemetery</b>		20c. Location - City or Town, State <b>10-6-00 Cheltenham, Md.</b>	
21. Signature of Funeral Service Licensee <b>John P. Knisley</b> M01164			22. Name and Address of Facility <b>The Hunt Funeral Home, Inc.</b> <b>P. O. Box 156, Waldorf, Maryland 20604</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Liver Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Physician</b> : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner</b> : On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Dr. Krishan Mathur</b>		29c. License number <b>D28352</b>		29d. Date signed (Month, Day, Year) <b>October 3, 2000</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646</b>					
31. Date filed (Month, Day, Year) <b>OCT 05 2000</b>		32. Registrar's Signature <b>B. Sparks</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32584

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RALPH AMOR GARCIA

2. Date of Death

Month Day Year  
Oct. 04, 2000

3. Time of Death

2:45 AM

4a. Facility Name (If not institution, give street and number)

Civista Medical Center

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

265-05-9517

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
SEPT. 25, 1917

9. Birthplace (State or Foreign Country)

FLORIDA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CHARLES

10c. City, Town or Location

LA PLATA

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6592 ELLENWOOD DRIVE

10f. Zip Code

20646

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: ARMY WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: PUERTO RICO

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CARPENTER

16b. Kind of Business/Industry

SELF EMPLOYED

17. Father's Name (First, Middle, Last)

ANTONIO GARCIA

18. Mother's Name (First, Middle, Maiden Surname)

FELOMENA AMOR

19a. Informant's Name/Relationship (Type, Print)

KATHERINE GARCIA-SPOUSE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METROPOLITAN CREMATORY 10-5-00 ALEXANDRIA, VA.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

M00479

22. Name and Address of Facility

RAYMOND FUNERAL SERVICE, P.A.

LA PLATA, MARYLAND 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PERICARDIAL EFFUSION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AORTIC STENOSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-44436

29d. Date signed (Month, Day, Year)

OCT 04 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ashvin J. Patel, MD P.O. Box 1620, Waldorf, Maryland 20604

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 05 2000

32. Registrar's Signature

B. Sparks

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32585

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elwood Lawrence GROVES</b>				2. Date of Death Month <b>09</b> Day <b>25</b> Year <b>2000</b>		3. Time of Death <b>9:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>320 Shenandoah Avenue</b>				4b. City, Town, or Location of Death <b>Loch Lynn</b>		4c. County of Death <b>Garrett</b>	
Funeral Director	5. Social Security Number <b>220-16-7122</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 8, 1925</b>	
	9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>MD</b>		10b. County <b>Garrett</b>		10c. City, Town or Location <b>Loch Lynn</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <b>1 Yes 2 No</b>		10e. Street and Number <b>320 Shenandoah Avenue</b>		10f. Zip Code <b>21550</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Installer/Repairman</b>		16b. Kind of Business/Industry <b>Telephone Company</b>			
	17. Father's Name (First, Middle, Last) <b>Carson Bruce Groves</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Pearl Virginia Hershman</b>		19a. Informant's Name/Relationship (Type, Print) <b>Doris M. Groves/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>320 Shenandoah Ave., Loch Lynn, Maryland 21550</b>	
	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrett Co. Mem. Gardens 9/28/00</b>		20c. Location - City or Town, State <b>Oakland, Maryland</b>			
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Stewart Funeral Home 32 S. Second St., Oakland, Md. 21550</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>e. renal failure</b>		Approximate Interval Between Onset and Death <b>4 wks</b>	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>chronic obstructive pulmonary disease</b> <b>peripheral vascular disease</b>		23c. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>		24a. Was an autopsy performed? <b>1 Yes 2 No</b>		24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>	
	25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>		27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No</b>	
	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29b. Signature and title of certifier 		29c. License number <b>D30035</b>		29d. Date signed (Month, Day, Year) <b>09-25-2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Donald R. Richter, M.D. 1533 Memorial Drive Oakland, MD 21550</b>		31. Date filed (Month, Day, Year) <b>SEP 28 2000</b>		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32586

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Rayfield Harold Guenther</b>						2. Date of Death Month Day Year <b>September 24, 2000</b>		3. Time of Death <b>5:10PM</b>						
	4a. Facility Name (If not institution, give street and number) <b>40522 Port Place</b>						4b. City, Town, or Location of Death <b>Leonardtown</b>		4c. County of Death <b>St. Mary's</b>						
Funeral Director	5. Social Security Number <b>193-12-6060</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>February 16, 1920</b>		9. Birthplace (State or Foreign Country) <b>New Jersey</b>						
	Usual Residence of Decedent														
10a. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>Leonardtown</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10e. Street and Number <b>40522 Port Place</b>						10f. Zip Code <b>20650</b>		10g. Citizen of What Country? <b>U S A</b>							
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>							
15. Decedent's Education (Specify only highest grade completed) <b>12th Grade</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Land Developer</b>				16b. Kind of Business/Industry <b>Home Construction</b>							
17. Father's Name (First, Middle, Last) <b>William Guenther</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Evelyn Campbell</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Daniel J. Guenther (Son)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>41014 Breton View Drive, Leonardtown, Maryland 20650</b>									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Charles Memorial Gardens</b>			20c. Date <b>9/28/2000</b>		20d. Location - City or Town, State <b>Leonardtown, Maryland</b>							
21. Signature of Funeral Service Licensee <i>Michael Hain</i>						22. Name and Address of Facility <b>Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>cardiac arrest</b> Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death <b>days</b> <b>years</b></td> </tr> <tr> <td>b. <b>large myocardial infarction</b> Due to (or as a consequence of):</td> </tr> <tr> <td>c. <b>coronary artery disease</b> Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a. <b>cardiac arrest</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>days</b> <b>years</b>	b. <b>large myocardial infarction</b> Due to (or as a consequence of):	c. <b>coronary artery disease</b> Due to (or as a consequence of):	d.
Immediate Cause (Final disease or condition resulting in death)	a. <b>cardiac arrest</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death <b>days</b> <b>years</b>													
	b. <b>large myocardial infarction</b> Due to (or as a consequence of):														
	c. <b>coronary artery disease</b> Due to (or as a consequence of):														
	d.														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown															
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No															
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
29b. Signature and title of certifier <i>Jeffrey Brown</i>						29c. License number <b>042597</b>		29d. Date signed (Month, Day, Year) <b>9-26-00</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jeffrey Brown, MD Leonardtown, Maryland 20650</b>															
31. Date filed (Month, Day, Year) <b>SEP 27 2000</b>			32. Registrar's Signature <i>B. Sparks</i>												

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32587

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lena

Gough

2. Date of Death  
Month Day Year  
SEPTEMBER 11, 20003. Time of Death  
10:06PM

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtwn

4c. County of Death

St. Mary's

Funeral  
Director

5. Social Security Number

218-16-3337

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 11, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Lexington Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

46738 Willows Forest Lane

10f. Zip Code

20653

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Caleb White

18. Mother's Name (First, Middle, Maiden Surname)

Helen Eve Handy

19a. Informant's Name/Relationship (Type, Print)

Beverly J. Gough / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 223, Park Hall, Maryland 20667

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Luke's Methodist

Date

9-16-00

20c. Location - City or Town, State

Scotland, Maryland

21. Signature of Funeral Service Licensee

Mary B. Rizzo

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.

22955 Hollywood Road, Leonardtown, MD 20650-0279

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

18 hrs

2 days

yrs

yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

Systemic Lupus Erythematosus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA

25. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James P. Jarboe MD

29c. License number

D06419 MD.

29d. Date signed (Month, Day, Year)

9-13-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. JAMES JARBOE

HOLLYWOOD, MD. 20636

31. Date filed (Month, Day, Year)

SEP 14 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: LENA GOUGH

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32588

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jackie Lee Howe				2. Date of Death Month Day Year Sept 30 2000				3. Time of Death 1:05am	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 216-66-4913		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) Sept 13 1953		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Carroll		10c. City, Town or Location Westminster				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 301 St. Andrews Lane				10f. Zip Code 21158		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Media Specialist			16b. Kind of Business/Industry Public School System		
	17. Father's Name (First, Middle, Last) Garland Phillips				18. Mother's Name (First, Middle, Maiden Surname) Violet Warren					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Ernest J. Howe/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 St. Andrews Lane Westminster, MD 21158					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation		Date 10/2		20c. Location - City or Town, State Hampstead, MD			
	21. Signature of Funeral Services Licensee				22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Rectal cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Hospice					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier Helen Gordon				29c. License number D0051926		29d. Date signed (Month, Day, Year) September 30, 2000			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen Gordon 6601 N. Charles St, Baltimore MD 21204									
	31. Date filed (Month, Day, Year) OCT 03 2000				32. Registrar's Signature Benita Sparks					

ORIGINAL

Jackie Lee Howe, September 30, 2000  
Baltimore, Maryland 21215-0020 0105Apermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

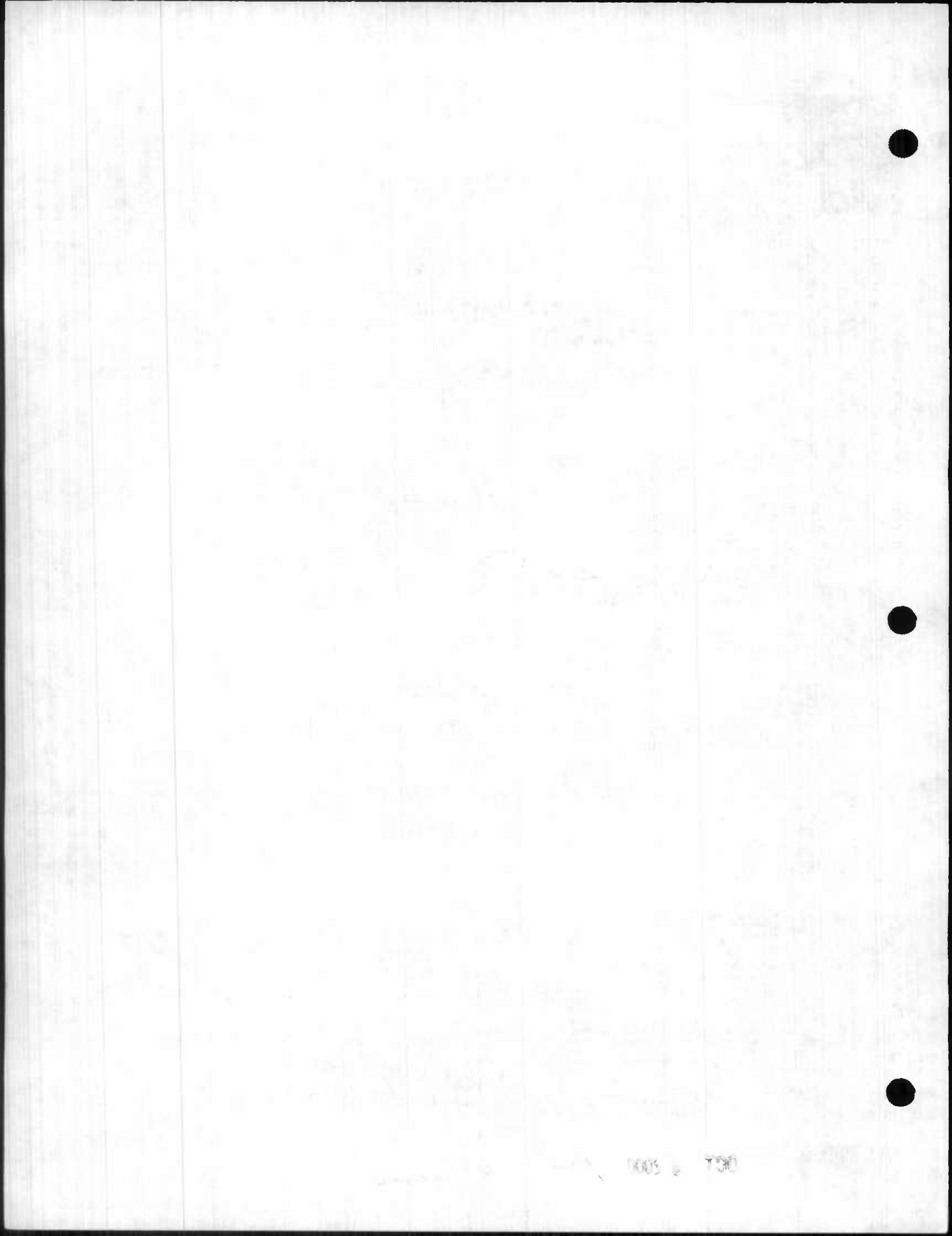
00 32589

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ruth Ann Heinefield				2. Date of Death Month Day Year October 3, 2000		3. Time of Death 0100	
	4a. Facility Name (If not institution, give street and number) Kent & Queen Anne's Hospital				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
Funeral Director	5. Social Security Number 217-80-8823		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 65 Yrs.		8. Date of Birth (Month, Day, Year) August 9, 1935	
	9. Birthplace (State or Foreign Country) Chestertown, Maryland		10a. State Maryland		10b. County Kent		10c. City, Town or Location Rock Hall	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 5228 Skinners Neck Road		10f. Zip Code 21661		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own home			
	17. Father's Name (First, Middle, Last) Silver Joseph Gsell, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Alice Morris			
	19a. Informant's Name/Relationship (Type, Print) Herman Heinefield				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5228 Skinners Neck Road, Rock Hall, Maryland 21661			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Wesley Chapel Cemetery		20c. Location - City or Town, State Rock Hall, Maryland		20d. Date 10/5/2000	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. ACUTE C.I. HEMORRHAGE Due to (or as a consequence of): f. ESOPHAGEAL VARICES Due to (or as a consequence of): g. RHEUMATOID ARTHRITIS Due to (or as a consequence of): h. FERTY'S SYNDROME							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier 				29c. License number 1-CC13824		29d. Date signed (Month, Day, Year) 10/3/00	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John C. Seymour, 122 Speer Road, Chestertown, Maryland 21620							
	31. Date filed (Month, Day, Year) OCT 4 2000				32. Registrar's Signature 			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

MAUDE HERRING

2. Date of Death

Month Day Year  
SEPT 23 2000

3. Time of Death

2:15 PM

4a. Facility Name (If not institution, give street and number)

GOODWILL MENNONITE HOME

4b. City, Town, or Location of Death

GRANTSVILLE

4c. County of Death

GARRETT CO

5. Social Security Number

170-36-4768

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
01-18-1904

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State  
MD

10b. County

GARRETT

10c. City, Town or Location

GRANTSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

891 DORSEY HOTEL RD

10f. Zip Code

21536

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4or 5+)  
416a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

SCHOOL TEACHER

16b. Kind of Business/Industry

PUBLIC SCHOOLS

17. Father's Name (First, Middle, Last)

ALBERT HERRING

18. Mother's Name (First, Middle, Maiden Surname)

MARY SIEHL

19a. Informant's Name/Relationship (Type, Print)

DARRELL W. BITTNER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4786 CUMBERLAND HWY., MEYERSDALE, PA 15552

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

UNION CEMETERY

Date

9-25-00

20c. Location - City or Town, State

MEYERSDALE, PA

21. Signature of Funeral Service Licensee

William R. Price CC0376

22. Name and Address of Facility W. R. PRICE FUNERAL HOME INC

325 MAIN ST MEYERSDALE, PA 15552

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Stroke  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner as stated

29b. Signature and title of certifier

James E. Beitzel MD

29c. License number

D 34079

29d. Date signed (Month, Day, Year)

Sept 24, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

James E. Beitzel MD

Grantsville MD

21536

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

B. Jones

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
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once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
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To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

MAJOR HERRING

CONDUCTED RESEARCH HERE

1922-23 X 96

CONDUCTED RESEARCH HERE

1922-23 X 96

MAJOR HERRING

CONDUCTED RESEARCH HERE

1922-23 X 96

1922-23

X

1922-23

X

JOHN TANNER

1922-23

ALBERT HERRING

MARY SIEG

RESEARCH IN BIRMINGHAM AND HOUSTON, TX 1922

1922-23 X 96

RESEARCH IN BIRMINGHAM AND HOUSTON, TX 1922

RESEARCH IN BIRMINGHAM AND HOUSTON, TX 1922

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32591

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gertrude Surratt Hoskins</b>				2. Date of Death Month Day Year <b>September 15, 2000</b>		3. Time of Death <b>7:30 p.m.</b>		
	4a. Facility Name (If not institution, give street and number) <b>36676 Wilson Drive</b>				4b. City, Town, or Location of Death <b>Bushwood</b>		4c. County of Death <b>St. Mary's</b>		
Funeral Director	5. Social Security Number <b>577-22-2322</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 4, 1913</b>		9. Birthplace (State or Foreign Country) <b>South Carolina</b>	
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>Bushwood</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>36676 Wilson Drive</b>				10f. Zip Code <b>20618</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Own home</b>			
17. Father's Name (First, Middle, Last) <b>Benjamin Drakeford</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rachel (Unknown)</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Willie Mae Clements / Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>#8 Emmett Street, Albany, New York 12204</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland National Memorial Park</b>		20c. Location - City or Town, State <b>9-20-00 Laurel, Maryland</b>			
21. Signature of Funeral Service Licensee <b>Edward N. Brinsfield, Jr. M00052</b>				22. Name and Address of Facility <b>Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Myocardial infarction</b> Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Dua to (or as a consequence of):</b> <b>c. Dua to (or as a consequence of):</b> <b>d. Dua to (or as a consequence of):</b>								Approximate Interval Between Onset and Death <b>one month</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <b>SC Baby M.D.</b>							
29c. License number <b>D54346</b>		29d. Date signed (Month, Day, Year) <b>9/18/00</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Chandra B. Sajja, M.D., 24035 Three Notch Road, Hollywood, Maryland 20636</b>									
31. Date filed (Month, Day, Year) <b>SEP 20 2000</b>		32. Registrar's Signature <b>B. Sparks</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





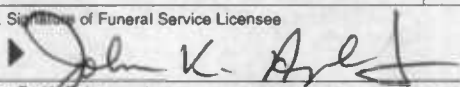
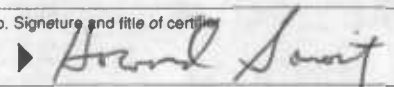
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32592

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Opal Jennings				2. Date of Death Month Day Year Oct 1 2000				3. Time of Death 10:35pm	
	4a. Facility Name (If not institution, give street and number) 4801 Band Hall Hill Road				4b. City, Town, or Location of Death Westminster				4c. County of Death Carroll	
Funeral Director	5. Social Security Number 212-26-0838		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) Oct 2 1928		9. Birthplace (State or Foreign Country) CA	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Carroll		10c. City, Town or Location Westminster				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 4801 Band Hall Hill Road				10f. Zip Code 21158		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Asian		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) Henry Matsushige				18. Mother's Name (First, Middle, Maiden Surname) Manuella Paraza					
	19a. Informant's Name/Relationship (Type, Print) Edward B. Jennings, JR/son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1318 22nd St. N.W. Ste. 105 Washington, D.C.					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Carroll Cremation		Date 10/5		20c. Location - City or Town, State Hampstead, MD 20037			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Road Westminster, MD 21157					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Ovarian Cancer Due to (or as a consequence of):				Approximate Interval Between Onset and Death 8 months				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None Known								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number MD # D15552		29d. Date signed (Month, Day, Year) 10/2/00			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Howard Saenz, M.D., 555 S. Center St., Westminster, Md. 21157									
	State Registrar	31. Date filed (Month, Day, Year) OCT 03 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene 00 32593

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bernard Ignatius Johnson				2. Date of Death Month Day Year September 18, 2000		3. Time of Death 15:54
	4a. Facility Name (If not institution, give street and number) 22670 Bushwood Road				4b. City, Town, or Location of Death Bushwood		4c. County of Death St. Mary's
Funeral Director	5. Social Security Number 216-22-3418	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) September 5, 1927	9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent						
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Bushwood		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 22670 Bushwood Road				10f. Zip Code 20618		10g. Citizen of What Country? U S A	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6 Years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Principal		16b. Kind of Business/Industry High School	
17. Father's Name (First, Middle, Last) Julius Johnson				18. Mother's Name (First, Middle, Maiden Surname) Mary Lillian Mattingly			
19a. Informant's Name/Relationship (Type, Print) Harvey I. Bailey (Friend)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23100 Chestnut Hill Lane, Avenue, Maryland 20609			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart Catholic Cemetery		20c. Date 9/22/2000		20d. Location - City or Town, State Bushwood, Maryland	
21. Signature of Funeral Service Licensee <i>Michael Flori Gardiner</i>				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  a. <i>Acute Myocardial Infarction</i>  Due to (or as a consequence of):  b.  Due to (or as a consequence of):  c.  Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>COPD</i>  <i>Congestive Heart Failure</i>							23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D19917		29d. Date signed (Month, Day, Year) 9/21/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James C. Boyd, MD California, Maryland 20619							
31. Date filed (Month, Day, Year) SEP 21 2000				32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10-20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32594

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Raymond Michael Kahl</b>				2. Date of Death Month Day Year <b>September 22, 2000</b>				3. Time of Death <b>3:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>9021 Kahl Avenue</b>				4b. City, Town, or Location of Death <b>Perry Hall</b>				4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>215-32-2590</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 16, 1925</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>				10b. County <b>Baltimore</b>	
To Be Completed by Funeral Director	10c. City, Town or Location <b>Perry Hall</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number <b>9021 Kahl Avenue</b>				10f. Zip Code <b>21128</b>				10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th Grade</b>		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business/Industry <b>Baltimore County Recreation and Parks</b>			
	17. Father's Name (First, Middle, Last) <b>Joseph Kahl</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Magdalene Schrenker</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Erma F. Kahl (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9021 Kahl Avenue, Perry Hall, MD 21128</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Joseph Church Cem.</b>		Date <b>9/25/00</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>			
	21. Signature of Funeral Service Licensee <b>Brian A. Wilken</b>				22. Name and Address of Facility <b>Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. METASTATIC NON SMALL CELL LUNG</b>				Approximate Interval Between Onset and Death <b>2 MONTHS</b>					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>									
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number <b>231775</b>				29d. Date signed (Month, Day, Year) <b>SEPTEMBER 25, 2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHN R. EDWARDS, MD. 7112 BELAIR ROAD FALLSOWN, MARYLAND 21047</b>									
	31. Date filed (Month, Day, Year) <b>SEP 26 2000</b>		32. Registrar's Signature <b>B. Sparks</b>							

ORIGINAL






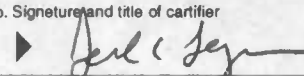
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State of Maryland / Department of Health and Mental Hygiene

00 32595

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Edwin Lincoln Kinkaide</b>				2. Date of Death Month Day Year <b>October 4, 2000</b>				3. Time of Death <b>0200</b>	
	4a. Facility Name (If not institution, give street and number) <b>Heron Point</b>				4b. City, Town, or Location of Death <b>Chestertown</b>				4c. County of Death <b>Kent</b>	
Funeral Director	5. Social Security Number <b>121-09-4584</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>February 12, 1917</b>		9. Birthplace (State or Foreign Country) <b>Glenwood, New York</b>	
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Kent</b>		10c. City, Town or Location <b>Chestertown</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>215 Heron Point</b>				10f. Zip Code <b>21620</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales Manager/Industrial Mech. Eng.</b>				16b. Kind of Business/Industry <b>Pipeline/Oil &amp; Gas</b>				17. Father's Name (First, Middle, Last) <b>Edwin S. Kinkaide</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Raynor</b>				19a. Informant's Name/Relationship (Type, Print) <b>Perry Kinkaide</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>45 Windemere Crescent St. Albert, Alberta Canada T8N3P1</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Cremation Center, LLC</b>				20c. Location - City or Town, State <b>10/4/2000 Stevensville, Maryland</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Fellows, Helfenbein &amp; Newman Funeral Home, P.A.</b> <b>130 Speer Road, Chestertown, Maryland 21620</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier 				29c. License number <b>10013824</b>				29d. Date signed (Month, Day, Year) <b>10-4-00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John C. Seymour, 122 Speer Road, Chestertown, Maryland 21620</b>				31. Date filed (Month, Day, Year) <b>OCT 5 2000</b>				32. Registrar's Signature 		

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32596

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Louise Koppelman				2. Date of Death Month Day Year September 25, 2000		3. Time of Death 3:45 p.m.	
	4a. Facility Name (If not Institution, give street and number) 12430 Augustine Herman Highway				4b. City, Town, or Location of Death Kennedyville		4c. County of Death Kent	
Funeral Director	5. Social Security Number 219-18-0950	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) December 4, 1926		9. Birthplace (State or Foreign Country) Baltimore, Maryland
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland		10b. County Kent		10c. City, Town or Location Kennedyville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10a. Street and Number 12430 Augustine Herman Highway				10f. Zip Code 21645		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collega (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Hans Geissdorfer				18. Mother's Name (First, Middle, Maiden Surname) Kate Schwabb			
	19a. Informant's Name/Relationship (Type, Print) George E. Koppelman, Jr./Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12430 Augustine Herman Hwy, Kennedyville, MD 21645			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 9/25/2000		20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Amyloidosis of Lungs with Respiratory Failure Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 2 years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Thrombocytopenia, idiopathic Waldenström's Macroglobulinemia Temporal Arteritis							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		28e. Date signed (Month, Day, Year) 9/27/00					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number D1703C		29d. Date signed (Month, Day, Year) 9/27/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Susan K. Ross, MD 516 Washington Ave. Chestertown MD 21620							
State Registrar	31. Date filed (Month, Day, Year) SEP 28 2000		32. Registrar's Signature 					

ORIGINAL

SEP 3 1966

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State of Maryland / Department of Health and Mental Hygiene

00 32597

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Melvin Edgar Lederer, Jr.</b>				2. Date of Death Month <b>September</b> Day <b>27</b> Year <b>2000</b>		3. Time of Death <b>1328</b>		
	4a. Facility Name (If not institution, give street and number) <b>Fallston General Hospital</b>				4b. City, Town, or Location of Death <b>Fallston</b>		4c. County of Death <b>Harford</b>		
Funeral Director	5. Social Security Number <b>218-26-6188</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 14, 1930</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Bel Air</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1205 Fordham Ct.</b>		10f. Zip Code <b>21014</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korean</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>3</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner/Operator</b>		16b. Kind of Business/Industry <b>Industrial Motor Sales</b>		17. Father's Name (First, Middle, Last) <b>Melvin Edgar Lederer, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Ethyle Ellen Gott</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Carol Lee Lederer / Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1205 Fordham Road, Bel Air, Maryland 21014</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp</b>		20c. Location - City or Town, State <b>9-29-00 Towson, Maryland</b>	
21. Signature of Funeral Service Licensee <i>Charles A. Engel</i>		22. Name and Address of Facility <b>McComas Funeral Home, P.A.</b> <b>1317 Cokesbury Road, Abingdon, Maryland 21009</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>a. ACUTE RENAL FAILURE</b> Due to (or as a consequence of): <b>b. SEPSIS SYNDROME</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Metastatic Prostate Cancer.</b> <b>Disseminated Intravascular Coagulation.</b>		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>J. Kevin Lynch MD</i>		29c. License number <b>D35012</b>		29d. Date signed (Month, Day, Year) <b>September 28, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Kevin Lynch MD 2 North Ave. Bel Air, Md. 21014.</b>	
31. Date filed (Month, Day, Year) <b>OCT 1 - 2000</b>		32. Registrar's Signature <i>B. Sparks</i>							





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State of Maryland / Department of Health and Mental Hygiene

00 32598

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Arthur Liberatore</b>				2. Date of Death Month Day Year <b>Sept. 28 2000</b>		3. Time of Death <b>6:55am</b>		
	4e. Facility Name (If not institution, give street and number) <b>101 Vandiver Court</b>				4b. City, Town, or Location of Death <b>Havre de Grace</b>		4c. County of Death <b>Harford</b>		
Funeral Director	5. Social Security Number <b>215-16-9438</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>11/20/1922</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Havre de Grace</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>101 Vandiver Court</b>		10f. Zip Code <b>21078</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW2</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machinist</b>		16b. Kind of Business/Industry <b>Government</b>					
17. Father's Name (First, Middle, Last) <b>Pasquale Liberatore</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lucia DiGuilio</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Katherine Marron- Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>411 Quaker Bottom Rd., Havre de Grace, MD 21078</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Erin Cemetery</b>		20c. Location - City or Town, State <b>10/2/00 Havre de Grace, MD</b>					
21. Signature of Funeral Service Licensee <b>Quaine M. Smith</b>				22. Name and Address of Facility <b>Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Lung Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death <b>9 months</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier <b>Daniel Shimmers MD</b>				29c. License number <b>D0053694</b>		29d. Date signed (Month, Day, Year) <b>September 28, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Daniel Shimmers MD 615 W. MacPhail Rd. Bel Air, MD 21014</b>									
31. Date filed (Month, Day, Year) <b>SEP 28 2000</b>				32. Registrar's Signature <b>B. Sparks</b>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar

1. The first part of the report  
describes the general situation  
of the country in 1950.  
It mentions the population  
and the main occupations.  
The second part of the report  
describes the economic situation  
in 1950. It mentions the  
main products and the  
main exports.  
The third part of the report  
describes the social situation  
in 1950. It mentions the  
main social problems and  
the main social reforms.  
The fourth part of the report  
describes the political situation  
in 1950. It mentions the  
main political parties and  
the main political reforms.

2. The second part of the report  
describes the economic situation  
in 1951. It mentions the  
main products and the  
main exports.  
The third part of the report  
describes the social situation  
in 1951. It mentions the  
main social problems and  
the main social reforms.  
The fourth part of the report  
describes the political situation  
in 1951. It mentions the  
main political parties and  
the main political reforms.


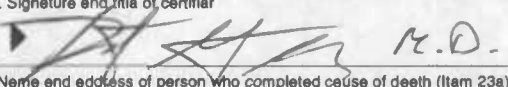

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32599

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gerald Edward Lampe</b>				2. Date of Death Month <b>September</b> Day <b>22</b> , Year <b>2000</b>		3. Time of Death <b>3:15 p.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>577-12-8542</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 11, 1918</b>	9. Birthplace (State or Foreign Country) <b>New York</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>			10d. Inside City Limits <b>1</b> Yes <b>2</b> No	
10e. Street and Number <b>1110 Parrish Drive</b>				10f. Zip Code <b>20851</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates: <b>WW 2</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) <b>10 th</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>			16b. Kind of Business/Industry <b>Home Improvement</b>	
17. Father's Name (First, Middle, Last) <b>Charles H. Lampe</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Isabelle M. Perry</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Margaret A. Lampe/wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1110 Parrish Dr., Rockville, MD 20851</b>				
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Asher Glade Cem.</b>		Date <b>Sept 26, 2000</b>		20c. Location - City or Town, State <b>Friendsville, MD</b>
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Acute Myocardial Infarction</b></p> <p>Due to (or as a consequence of):</p> <p>b. <b>Coronary Artery Disease</b></p> <p>Due to (or as a consequence of):</p> <p>c. </p> <p>Due to (or as a consequence of):</p> <p>d. </p> </div> <div style="width: 15%;"> <p>Approximate Interval Between Onset and Death</p> <p><b>Minutes</b></p> <p><b>Years</b></p> </div> </div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown		
						24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No		
						24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No		
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)						
27. Manner of Death <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier  M.D.				29c. License number <b>D37024</b>		29d. Date signed (Month, Day, Year) <b>September 22, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David G. Srour, M.D., 9901 Medical Center Dr., Rockville, MD 20850</b>								
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



State of Maryland / Department of Health and Mental Hygiene 00 32600

### Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) Lawrence Eugene Maskell

2. Date of Death Month Sept. 30, 2000 Day Year 10:45A.M.

3. Time of Death

4a. Facility Name (If not institution, give street and number) 2706 Aspen Drive

4b. City, Town, or Location of Death Hampstead

4c. County of Death Carroll

5. Social Security Number 212-26-3615

6. Sex 1 M 2 F

7. Age (In yrs. last birthday) 71 Yrs.

8. Date of Birth (Month, Day, Year) Jan. 11, 1929

9. Birthplace (State or Foreign Country) Maryland

10a. State Maryland

10b. County Carroll

10c. City, Town or Location Hampstead

10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 2706 Aspen Drive

10f. Zip Code 21074

10g. Citizen of What Country? United States

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: White

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Right away Specialist

16b. Kind of Business/Industry BGE

17. Father's Name (First, Middle, Last) Charles Leo Maskell

18. Mother's Name (First, Middle, Maiden Surname) Annie E. McCluskey

19a. Informant's Name/Relationship (Type, Print) Theresa M. Maskell (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2706 Aspen Drive Hampstead, Maryland 21074

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Redeemer

20c. Location - City or Town, State Baltimore, Maryland

20d. Date Oct. 3

21. Signature of Funeral Service Licensee Steven W. Eline

22. Name and Address of Facility Eline Funeral Home 934 S. Main Street Hampstead, Md. 21074

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EMPHYSEMA

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number D 29246

29d. Date signed (Month, Day, Year) 10.2.00.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Natvarlal Rajpura MD 217 Washington Hgt Med. Ctr., Westminster, MD 21157

31. Date filed (Month, Day, Year) OCT 02 2000

32. Registrar's Signature

State Registrar

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32601

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOAN HENRIETTA MITCHELL

2. Date of Death

Month Day Year  
October 2 2000

3. Time of Death

1020A

4a. Facility Name (If not Institution, give street and number)

FALLSTON GENERAL HOSPITAL

4b. City, Town, or Location of Death

FALLSTON

4c. County of Death

HARFORD

Funeral  
Director

5. Social Security Number

055-28-1202

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Oct. 22, 1936

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1940 Mark Drive

10f. Zip Code

21040

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Drug Store

17. Father's Name (First, Middle, Last)

Kenneth Lewis Bowland

18. Mother's Name (First, Middle, Maiden Surname)

Florence Rose Stauder

19a. Informant's Name/Relationship (Type, Print)

Thomas J. Mitchell / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1940 Mark Drive, Edgewood, MD 21040

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hilltop Service Corp.

Date

10-5-00

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McComas Funeral Home, P.A.  
1317 Cokesbury Road, Abingdon, Maryland 2100923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CHRONIC OBSTRUCTIVE AIRWAYS DISEASE

Due to (or as a consequence of):

b. ATRIAL FIBRILLATION

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

&gt; 10 years

few days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2. ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Charles K. Kuhn MD

29c. License number

D50040

29d. Date signed (Month, Day, Year)

10-03-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1308 Business Center Way #102, Edgewood, MD 21040

31. Date filed (Month, Day, Year)

OCT 8 - 2000

32. Registrar's Signature

B. Spate

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, BN  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

*[Handwritten signature]* *[Handwritten initials]* 0005 - 8 T30

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32602

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIRGINIA MUSSER</b>				2. Date of Death Month Day Year <b>September 26 2000</b>		3. Time of Death <b>9:22 AM</b>		
	4e. Facility Name (If not institution, give street and number) <b>Fallston General Hospital</b>				4b. City, Town, or Location of Death <b>Fallston</b>		4c. County of Death <b>Harford</b>		
Funeral Director	5. Social Security Number <b>212-22-2325</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>2/4/1915</b>		
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>MD.</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Monkton</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>3962 Old York Road</b>		10f. Zip Code <b>21111</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b>		College (1-4 or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Waitress</b>		16b. Kind of Business/Industry <b>Restaurant</b>			
17. Father's Name (First, Middle, Last) <b>Calvin DeBoard</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Blevins</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Carl T. Musser /Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10 a,b,c,e,f</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Mem. Gar.</b>		20c. Location - City or Town, State <b>2000 Bel Air, Maryland</b>		20d. Date <b>9/29</b>			
21. Signature of Funeral Service Licensee <b>M. Gladden Kurtz III</b>				22. Name and Address of Facility <b>E.G. Kurtz &amp; Son Funeral Home, P.A. Jarrettsville, Maryland</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>Hypoxemia</b> Due to (or as a consequence of):		b. <b>Brain Stem Infarction</b> Due to (or as a consequence of):		c. <b>Hemorrhagic Infarct brain</b> Due to (or as a consequence of):		d. <b>Atrial Fibrillation</b> Due to (or as a consequence of):	
						1 hour		1 day	
						1 day		1 day	
						1 day		1 day	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Jude Muneses MD</b>				29c. License number <b>D53462</b>	
				29d. Date signed (Month, Day, Year) <b>9/26/00</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jude Muneses, MD 7845 Oakwood Road Glen Burnie, MD 21061</b>				31. Date filed (Month, Day, Year) <b>SEP 28 2000</b>				32. Registrar's Signature <b>B. Sparks</b>	

11-10-1954

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State of Maryland / Department of Health and Mental Hygiene

00 32603

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Thomas Mercer</i>				2. Date of Death Month <i>September</i> Day <i>26</i> Year <i>2000</i>				3. Time of Death <i>3:00 AM</i>		
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland University Hospital</i>				4b. City, Town, or Location of Death <i>Baltimore</i>				4c. County of Death <i>Baltimore</i>		
Funeral Director	5. Social Security Number <i>221-28-8166</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <i>53</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Oct. 10, 1946</i>		9. Birthplace (State or Foreign Country) <i>USA</i>		
	10a. State <i>Maryland</i>		10b. County <i>Kent</i>		10c. City, Town or Location <i>Rock Hall</i>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <i>6412 Edesville Rd.</i>					10f. Zip Code <i>21661</i>			10g. Citizen of What Country? <i>United States</i>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>White</i>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9yrs</i> College (1-4 or 5+) <i></i>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Painter</i>			16b. Kind of Business/Industry <i>Painting</i>			
17. Father's Name (First, Middle, Last) <i>Thomas Henry Mercer</i>					18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Chadwick</i>						
19a. Informant's Name/Relationship (Type, Print) <i>Tonya L. Mercer (daughter)</i>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6412 Edesville Rd. Rock Hall, Md. 21661</i>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Wesley Cemetery</i>			20c. Location - City or Town, State <i>9/29/00 Rock Hall</i>			
21. Signature of Funeral Service Licensee <i>Jason Fellows</i>					22. Name and Address of Facility <i>Fellows, Helffenbein &amp; Newnam Funeral Home 370 W. Cypress St. Millington, Md. 21651</i>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Acute Myocardial Infarction</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>										Approximate Interval Between Onset and Death <i>5 days</i>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>Paul A. Sack MD</i>					29c. License number <i>P14666</i>			29d. Date signed (Month, Day, Year) <i>September 26, 2000</i>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>PAUL SACK 22 South Green St. Baltimore, MD 21201</i>											
31. Date filed (Month, Day, Year) <i>SEP 29 2000</i>					32. Registrar's Signature <i>B. Sparks</i>						

ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32604

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Michael A. McClintock

2. Date of Death

Month Day Year  
October 4, 2000

3. Time of Death

3:50 PM

4a. Facility Name (If not institution, give street and number)

128 Ravine St.

4b. City, Town, or Location of Death

Grantsville

4c. County of Death

Garrett

Funeral  
Director

5. Social Security Number

178-60-0115

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

35 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
03/03/65

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Grantsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

128 Ravine St.

10f. Zip Code

21536

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
216a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Iron Worker

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Larry McClintock

18. Mother's Name (First, Middle, Maiden Surname)

Linda Stairs

19a. Informant's Name/Relationship (Type, Print)

Karen McClintock/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

128 Ravine St., Grantsville, MD 21536

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Countryside Crematory

Date

10/09/00

20c. Location - City or Town, State

Davidsville, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Humbert Funeral Home

P. O. Box 37, Confluence, PA 15424

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

colon carcinoma with metastasis

Approximate  
Interval Between  
Onset and Death

one year

Immediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)
☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D27205

29d. Date signed (Month, Day, Year)

10/05/00

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Karl E. Schwalm, M.D. 311 N. Fourth St Oakland, MD 21550

31. Date filed (Month, Day, Year)

OCT 16 2000

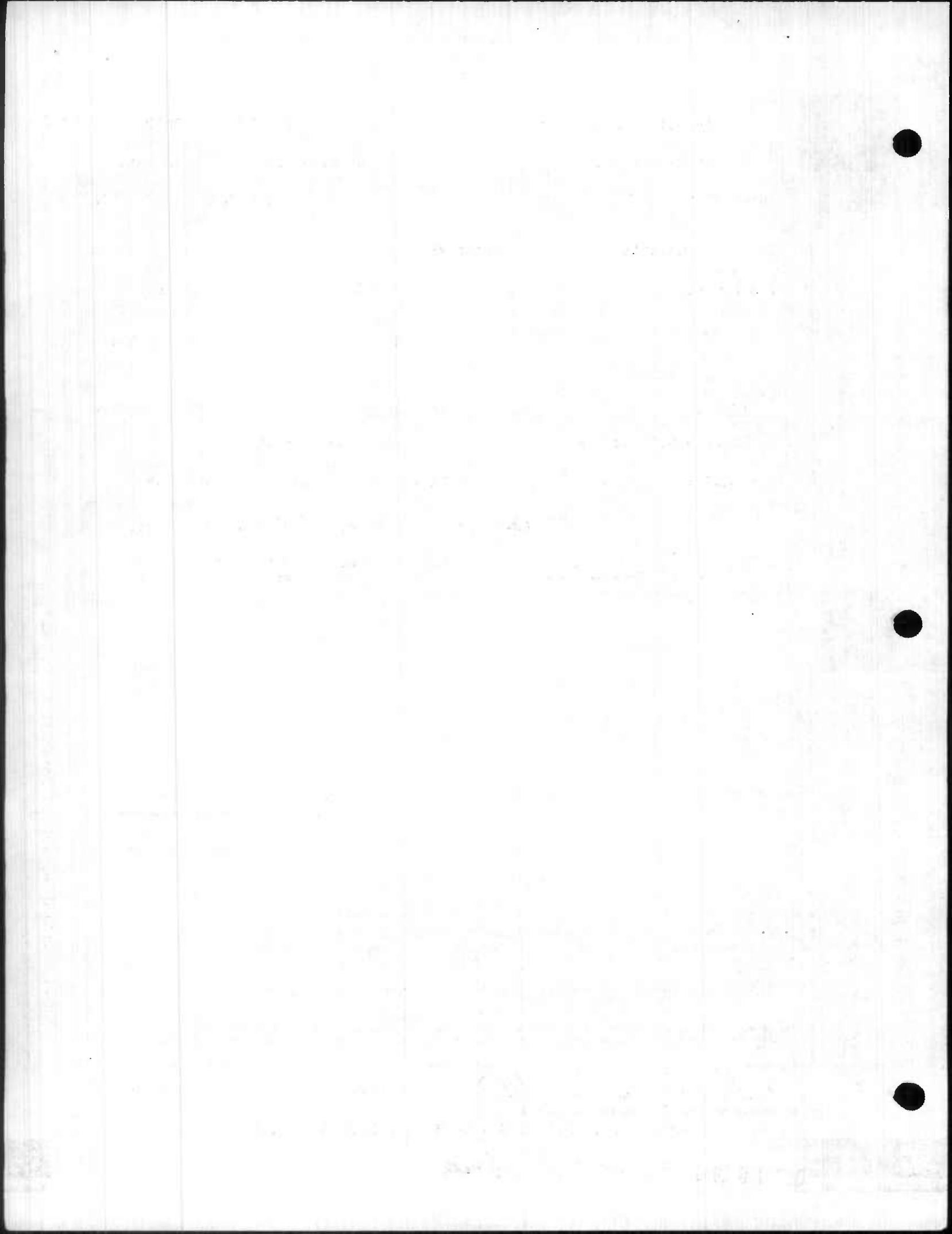
32. Registrar's Signature

State  
RegistrarPhysician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32605

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Florence Catherine Murray

2. Date of Death

October 1 2000

3. Time of Death

2028

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

178-36-3052

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

8/9/44

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Somerset

10c. City, Town or Location

Westover

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

30041 Revells Neck Rd.

10f. Zip Code

21871

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

2 yrs.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private family Home

17. Father's Name (First, Middle, Last)

George Washington

18. Mother's Name (First, Middle, Maiden Surname)

Novada Brown

19a. Informant's Name/Relationship (Type, Print)

William Murray - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30041 Revells Neck Rd, Westover, Md. 21871

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Morris Cemetery

Date

10/7/00

20c. Location - City or Town, State

Phoenixville, Pa.

21. Signature of Funeral Service Licensee

Anthony E. Ward Jr.

22. Name and Address of Facility

Anthony E Ward Funeral Home  
30039 Hampden Ave, Princess Anne Md 21853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. ACHD

Due to (or as a consequence of):

c. HTN

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ESRD - Peritoneal dialysis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

D-53611

29d. Date signed (Month, Day, Year)

10/1/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAZI KHAN 547-6 Riverside Dr, Salisbury, MD 21801

31. Date filed (Month, Day, Year)

OCT 04 2000

32. Registrar's Signature

Geneva G. Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

18-20-2001

20-20-2001

20-20-2001

20-20-2001

20-20-2001

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20-20-2001

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32606

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>XAVIER AMAN MATTHEWS</b>				2. Date of Death Month <b>SEP</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>11:10 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>	
5. Social Security Number <b>none</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>none</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 29, 2000</b>	
9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>24 Stokes Road</b>		10f. Zip Code <b>20814</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>none</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>none</b>		16b. Kind of Business/Industry <b>none</b>			
17. Father's Name (First, Middle, Last) <b>Travis Matthews</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Atonya Richardson</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Travis Matthews - Father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>24 Stokes Road Bethesda, MD 20814</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenlawn Cemetery</b>		Date <b>10/5/00</b>		20c. Location - City or Town, State <b>Tarboro, NC</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Metropolitan Funeral Service, Inc.</b> <b>5517 Vine Street Alexandria, VA 22310</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. SEVERE PULMONARY HYPOPLASIA</b> Due to (or as a consequence of): <b>b. CYSTIC RENAL DYSPLASIA</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  MD		29c. License number <b>A52356 (CA)</b>		29d. Date signed (Month, Day, Year) <b>2 OCT 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>R.C. TAN, LCDR, MC, USNR</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>NATIONAL NAVAL MEDICAL CENTER</b> <b>BETHESDA MD 20889-5600</b>			
31. Date filed (Month, Day, Year)		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be delivered for use as the burial-transit

State  
Registrar

22nd Nov 1911



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32607

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elfreda Lillian Merritt</b>		2. Date of Death Month <b>September</b> Day <b>24</b> Year <b>2000</b>		3. Time of Death <b>8:30 p.m.</b>
	4a. Facility Name (If not institution, give street and number) <b>50465 Fresh Pond Neck Road</b>		4b. City, Town, or Location of Death <b>Ridge</b>		4c. County of Death <b>St. Mary's</b>
Funeral Director	5. Social Security Number <b>215-56-9369</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>51</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Apr. 13, 1949</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10e. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>Ridge</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>50465 Fresh Pond Neck Road</b>		10f. Zip Code <b>20680</b>	
10g. Citizen of What Country? <b>United States</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+) <b>Collega</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Accountant - Self Employed</b>		16b. Kind of Business/Industry <b>Accounting</b>		17. Father's Name (First, Middle, Last) <b>Franklin B. Wood, Sr.</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Elfreda Lillian Lettau</b>		19a. Informant's Name/Relationship (Type, Print) <b>William E. Merritt / Husband</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>50465 Fresh Pond Neck Road, Ridge, Maryland 20680</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Michael's Cemetery</b>		20c. Location - City or Town, State <b>9-27-00 Ridge, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Edward N. Brinsfield, Jr. M00052</b>		22. Name and Address of Facility <b>Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>BRAIN TUMOR (R) TEMPORAL GLIOMATOSA MULTIFOCAL</b> Due to (or as a consequence of): <b>(April 1999)</b>			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA      Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Therese J. ...</b>		29c. License number <b>D34539</b>		29d. Date signed (Month, Day, Year) <b>9.26.00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Khalid M. Husain, M.D., 22576 MacArthur Boulevard, California, Maryland 20619</b>					
31. Date filed (Month, Day, Year) <b>SEP 27 2000</b>		32. Registrar's Signature <b>P. Sparks</b>			

ORIGINAL

100

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

00 32608

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Richard McCreary, Sr.

2. Date of Death  
Month Day Year  
September 13, 20003. Time of Death  
1:12 PM

4a. Facility Name (If not institution, give street and number)

Charlotte Hall Veterans Home

4b. City, Town, or Location of Death

Charlotte Hall

4c. County of Death

St. Mary's

Funeral  
Director

5. Social Security Number

579-16-9473

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 27, 1923

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Piney Point

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16434 Thompson Road

10f. Zip Code

20674

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5th

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Roofing Inspector

16b. Kind of Business/Industry

DC Government

17. Father's Name (First, Middle, Last)

Robert Franklin McCreary

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Mary O'Conner

19a. Informant's Name/Relationship (Type, Print)

Ethel K. McCreary (Spouse)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 216, Piney Point, Maryland 20674

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arlington National Cemetery 9/19/00

Date

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.

P.O. Box 270, Leonardtown, Maryland 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia.

Due to (or as a consequence of):

b. Coronary Atherosclerosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Approx - 5 minutes more than 1 year.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease.

Dementia.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ryan - C. Surana

29c. License number

D 50653

29d. Date signed (Month, Day, Year)

9-13-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5851- Deale Churchton Rd. Deale MD 20751

31. Date filed (Month, Day, Year)

SEP 14 2000

32. Registrar's Signature

P. [Signature]

State  
Registrar

Joseph R. McCreary 1:12pm 9/13/00

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32609

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Daniel Arthur McDonnell				2. Date of Death Month Day Year September 15 2000		3. Time of Death 09:52 P.M.	
	4a. Facility Name (If not institution, give street and number) Saint Mary's Hospital				4b. City, Town, or Location of Death Leonardtwn		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 303-84-1460	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 29 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) August 3, 1971		9. Birthplace (State or Foreign Country) Indiana
	Usual Residence of Decedent							
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Leonardtwn		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 40441 Breton View Drive				10f. Zip Code 20650		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Aviation Ordinance Man		16b. Kind of Business/Industry U.S. Navy		
17. Father's Name (First, Middle, Last) Robert A. McDonnell				18. Mother's Name (First, Middle, Maiden Surname) Carol Ann Sniadecki				
19a. Informant's Name/Relationship (Type, Print) Carol Ann McDonnell (Mother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 52399 Nonte Vista Drive, Granger, Indiana 46530				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Elkhart Cremation Service		20c. Location - City or Town, State 9/21/00 Elkhart, Indiana				
21. Signature of Funeral Service Licensee Michael L. Gardiner				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650				
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 9-15-2000		28b. Time of Injury 2:25 M		28c. Injury et Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred Subject was operator of motorcycle which collided with a car		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Street		28f. Location (Street and Number or Rural Route Number, City or Town, State) St. Marys County, Maryland		
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Stephen A. Radentz, M.D.				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) September 17, 2000		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201								
31. Date filed (Month, Day, Year) SEP 19 2000		32. Registrar's Signature B. Sparks						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32610

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dorothy Hope Milford				2. Date of Death Month Day Year September 6, 2000		3. Time of Death 9:40 a.m.	
	4a. Facility Name (If not institution, give street and number) 37285 River Springs Road				4b. City, Town, or Location of Death Avenue		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 579-30-6607		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	8. Date of Birth (Month, Day, Year) Dec. 29, 1917		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent							
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Avenue		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 37285 River Springs Road				10f. Zip Code 20609		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Beautician		16b. Kind of Business/Industry Beauty Salon		
17. Father's Name (First, Middle, Last) Stephen Lawrence Vallandingham, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Julia Marie Bowles				
19a. Informant's Name/Relationship (Type, Print) Billy G. Milford / Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37285 River Springs Road, Avenue, Maryland 20609				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Vallandingham Cemetery		20c. Location - City or Town, State 9-11-00 Clements, Maryland				
21. Signature of Funeral Service Licensee Edward N. Brinsfield, Jr. M00052				22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650-0279				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cerebrovascular Accident</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <u>[Signature]</u>				29c. License number 85230		29d. Date signed (Month, Day, Year) 9/8/00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) David C. Allen, M.D., 22815 Washington Street, Leonardtown, Maryland 20650								
31. Date filed (Month, Day, Year) SEP 11 2000				32. Registrar's Signature <u>[Signature]</u>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Stephen Francis Madjeski

2. Date of Death

Month Day Year  
August 29, 2000

3. Time of Death

1:12 A.M.

4a. Facility Name (If not institution, give street and number)

15031 Point Lookout Road

4b. City, Town, or Location of Death

St. Inigoes

4c. County of Death

St. Mary's

Funeral  
Director

5. Social Security Number

219-76-3023

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

41

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 29, 1959

9. Birthplace (State or Foreign Country)

Bermuda

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

St. Inigoes

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

48186 Jutland Farm Lane

10f. Zip Code

20684

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1980  
198413. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Charter Boat Captain

16b. Kind of Business/Industry

Fishing

17. Father's Name (First, Middle, Last)

Henry Robert Madjeski, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Temple Morris

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Madjeski Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

48186 Jutland Farm Lane, St. Inigoes, Maryland 20684

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Crematory  
Brinsfield-Echols

Date

9-1-00

20c. Location - City or Town, State

Charlotte Hall, MD

21. Signature of Funeral Service Licensee

Edward N. Brinsfield, Jr.

M00052

22. Name and Address of Facility

Brinsfield Funeral Home, P.A., 22955 Hollywood  
Road, Leonardtown, MD 2065023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Multiple Injuries  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☒ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)  
8/29/0028b. Time of  
Injury

0055 M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Driver of Motor Vehicle  
Impacts Fixed Objects28e. Place of Injury - At home, farm, street, factory, office,  
building, etc. (Specify)

Street

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)Rt 5  
St. Mary's County, Md29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Joseph Pestaner, M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

August 30, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

SEP 01 2000

32. Registrar's Signature

Benita G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

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Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
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once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32612

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GERALDINE DOLORES NASH

2. Date of Death

Sept. 28 2000

3. Time of Death

11:32 a.m.

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll County

Funeral  
Director

5. Social Security Number

213-26-6386

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 16 1930

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll County

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2159 Mayberry Road

10f. Zip Code

21158

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

homemaker

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

Lyman Cato Howe

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ellen McHugh

19a. Informant's Name/Relationship (Type, Print)

James T. Nash, Sr. / husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2159 Mayberry Road Westminster, Maryland 21158

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Joseph's Cemetery

Date

Oct. 2 2000

20c. Location - City or Town, State

Taneytown, Maryland

21. Signature of Funeral Service Licensee



M01072

22. Name and Address of Facility

Skiles Funeral Home  
136 East Baltimore Street Taneytown, MD 21787

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Emphysema  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.   
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D37573

29d. Date signed (Month, Day, Year)

September 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeff Zibell MD 25 Main Street Reisterstown MD 21136

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 02 2000

32. Registrar's Signature



ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32613

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT WARREN NAY

2. Date of Death

Month Day Year  
SEPTEMBER 22, 2000

3. Time of Death

5:35AM

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death

PERRY POINT

4c. County of Death

CECIL

Funeral  
Director

5. Social Security Number

235-30-3818

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 13, 1926

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

216 Marshall Drive

10f. Zip Code

21050

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Steel Worker

16b. Kind of Business/Industry

Steel Industry

17. Father's Name (First, Middle, Last)

Ralph Maxwell

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Nay

19a. Informant's Name/Relationship (Type, Print)

James M. Nay (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1300 Fallston Road, Fallston, MD 21047

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Highview Memorial Gardens 9/27/00

Date

20c. Location - City or Town, State

Fallston, Maryland

21. Signature of Funeral Service Licensee

Christina L. David

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.  
610 W. MacPhail Road, Bel Air, MD 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LEFT BASIL PNEUMONIA

Approximate Interval Between Onset and Death

2 WEEKS

Due to (or as a consequence of):

b. URINARY TRACT INFECTION

2 WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PROSTATE CANCER, STATUS POST PROSTATECTOMY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D19402

29d. Date signed (Month, Day, Year)

SEPTEMBER 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUKH AUJLA, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

[Signature]

State  
RegistrarNAME KNOWN TO PHYSICIAN: NAY, ROBERT WARREN  
Baltimore, Maryland 21215-0020To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32614

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gertrude A. Nordell</b>						2. Date of Death Month Day Year <b>September 25, 2000</b>		3. Time of Death <b>7:01 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Citizens Nursing Home</b>						4b. City, Town, or Location of Death <b>Harford</b>		4c. County of Death <b>Harford</b>		
Funeral Director	5. Social Security Number <b>213-46-3647</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar. 20, 1921</b>		9. Birthplace (State or Foreign Country) <b>Germany</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>				10d. Inside City Limits <b>1 Yes 2 No</b>			
10e. Street and Number <b>1015 Warwick Drive Apt. 2-D</b>						10f. Zip Code <b>21001</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>			12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b>			14. Race - American Indian, Black, White, etc. <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) <b>12</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>In home</b>			
17. Father's Name (First, Middle, Last) <b>Franz Thorwesten</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>UNK</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Edward A. Nordell (Spouse)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1015 Warwick Drive, Apt. 2-D, Aberdeen, MD 21001</b>					
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National Cemetery</b>		20c. Location - City or Town, State <b>10/2/00 Arlington, Virginia</b>					
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>CHF</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>1. Atrial Fibrillation 2. COPD 3. OA</b>										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>- Atrial Fibrillation - COPD - OA</b>								23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>			
								24a. Was an autopsy performed? <b>1 Yes 2 No</b>			
								24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>			
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>				26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>							
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>			
				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>											
29b. Signature and title of certifier 						29c. License number <b>D42800</b>		29d. Date signed (Month, Day, Year) <b>9/25/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>T. Biondo MD 319 S. Union, Hagerstown, MD 21078</b>											
31. Date filed (Month, Day, Year) <b>SEP 26 2000</b>				32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32615

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Margaret O'Brien Nicely</b>				2. Date of Death Month Day Year <b>September 23, 2000</b>				3. Time of Death <b>4:15 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Cherry Hill Assisted Living</b>				4b. City, Town, or Location of Death <b>Accident</b>				4c. County of Death <b>Garrett</b>	
Funeral Director	5. Social Security Number <b>226-26-6666</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b>		8. Date of Birth (Month, Day, Year) <b>Dec 8, 1925</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Garrett</b>		10c. City, Town or Location <b>Oakland</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>581 Snowy Creek Road</b>				10f. Zip Code <b>21550</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>Charles O'Brien</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Hannigan</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Alice Evans/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>581 Snowy Creek Rd., Oakland, MD 21550</b>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Alleghany Memorial Park</b>				Date <b>Sept 26, 00</b>		20c. Location - City or Town, State <b>Low Moor, VA</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death)				a. <b>progressive motor polyneuropathy</b> Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>2 yrs</b>		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				b. <b>profound B-12 deficiency</b> Due to (or as a consequence of):				<b>many years</b>		
				c. Due to (or as a consequence of):						
				d. Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic lymphocytic leukemia, s/p total gastrectomy for bleeding ulcers, mega colon</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Assisted Living</b>								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  <b>Margaret A. Kaiser</b>				29c. License number <b>D26650</b>		29d. Date signed (Month, Day, Year) <b>9/23/2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Margaret Kaiser, M.D.; 13079 Garrett Highway; Oakland, MD 21550</b>										
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

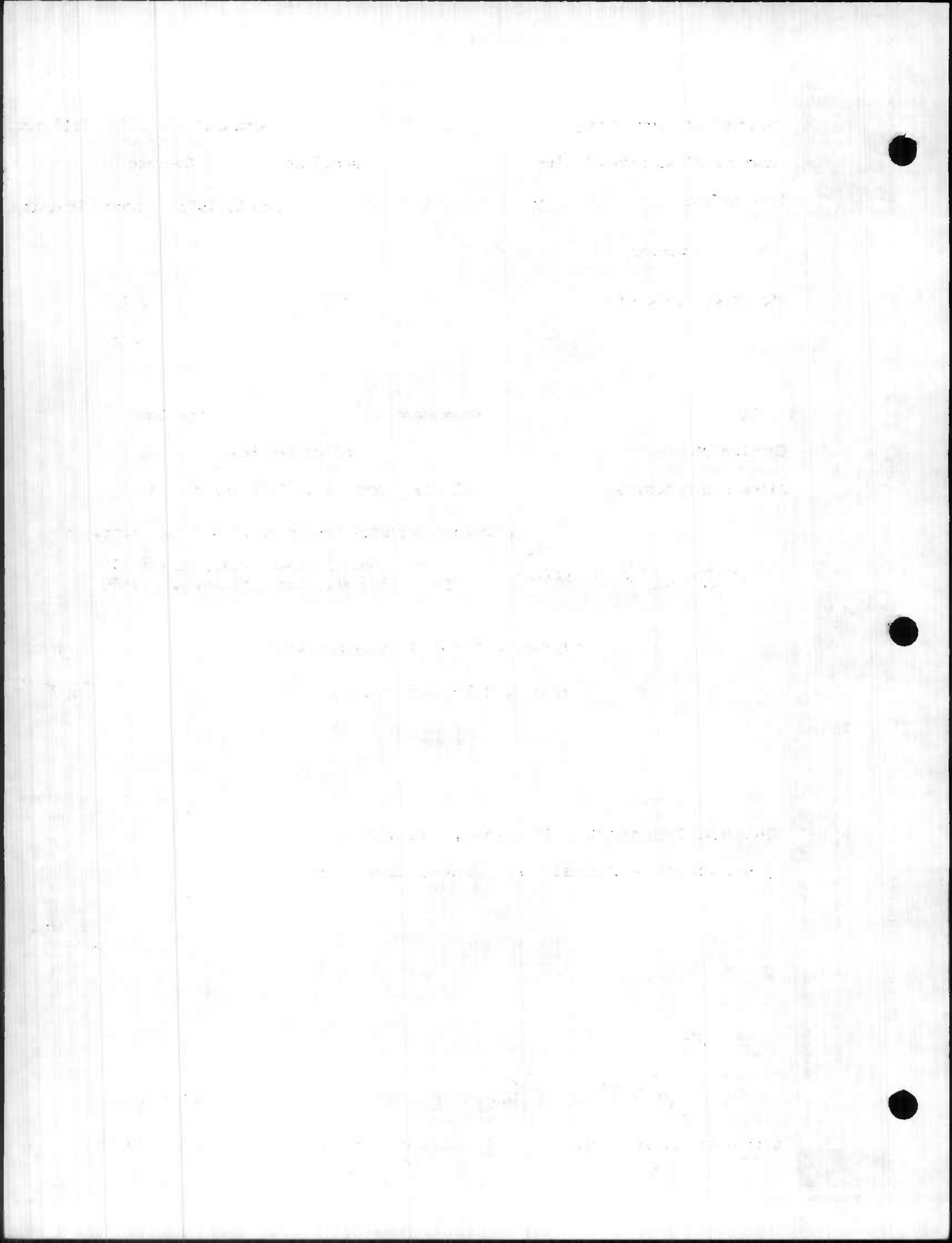
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32616

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joseph Neal Norris, Jr.				2. Date of Death Month Day Year September 9, 2000				3. Time of Death 13:35	
	4a. Facility Name (If not institution, give street and number) 21209 Woodmere Drive				4b. City, Town, or Location of Death Leonardtown				4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 216-28-1781		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) January 13, 1929		9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent				10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Leonardtown	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 21209 Woodmere Drive				10f. Zip Code 20650		10g. Citizen of What Country? U S A	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Owner/Operator				16b. Kind of Business/Industry Retail Food	
	17. Father's Name (First, Middle, Last) Joseph Neal Norris, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Eva Sedella Mayor					
	19a. Informant's Name/Relationship (Type, Print) Elizabeth A. Norris (Spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21209 Woodmere Drive, Leonardtown, Maryland 20650					
Physician /Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. George's Catholic Cemetery		20c. Date 9/12/2000		20d. Location - City or Town, State Valley Lee, Maryland			
	21. Signature of Funeral Service Licensee Michael A. Gardner				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Colon Carcinoma Due to (or as a consequence of):								Approximate Interval Between Onset and Death 3 yrs	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Biliary obstruction Liver metastases Due to (or as a consequence of):									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Biliary obstruction Liver metastases				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier William K. Kelly				29c. License number D39979	
	29d. Date signed (Month, Day, Year) 9/12/00				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William K. Kelly MD - OPIS - St Mary's Hosp. Leonardtown MD 20650					
State Registrar	31. Date filed (Month, Day, Year) SEP 12 2000		32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32617

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BERNICE A PATTERSON

2. Date of Death

Month Day Year  
SEPTEMBER 28 2000

3. Time of Death

11<sup>25</sup> pmFuneral  
Director

4a. Facility Name (If not institution, give street and number)

OAKCREST VILLAGE CARE CENTER

4b. City, Town, or Location of Death

BALTO.

4c. County of Death

BALTO.

5. Social Security Number

079-05-3193

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
June 30, 1914

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1113 Sunset Drive

10f. Zip Code

21014-2497

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Educator

16b. Kind of Business/Industry

Public School System

17. Father's Name (First, Middle, Last)

Ernest Perry

18. Mother's Name (First, Middle, Maiden Surname)

Marie Armstrong

19a. Informant's Name/Relationship (Type, Print)

Judith P. Merow (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1113 Sunset Drive, Bel Air, MD 21014-2497

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Green Mount Crematory

Date

9/29/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.  
610 W. MacPhail Road, Bel Air, MD 2101423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebral Vascular Accident

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Fredric S. Siercis M.D.

29c. License number

D22645

29d. Date signed (Month, Day, Year)

9/29/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FREDRIC S. SIERCIS M.D. 8800 WALTER BLVD. PARKVILLE, MD, 21234

31. Date filed (Month, Day, Year)

OCT 3 - 2000

32. Registrar's Signature

B. Spence

State  
RegistrarBernice Patterson D.O.D. 7 September 28, 2000 T.O.D. 2320  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, DH

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

100-8100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

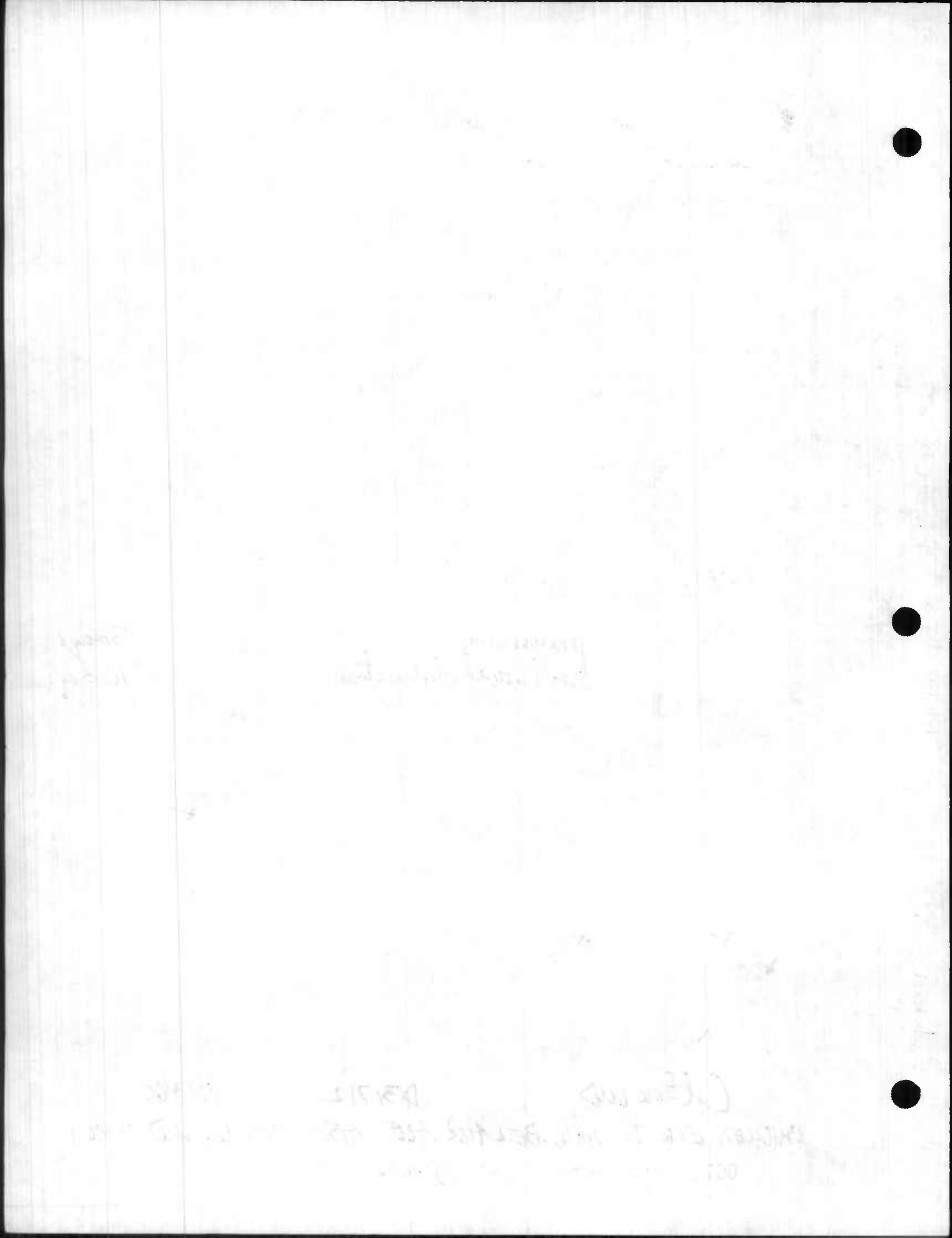
00 32618

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Minnie Catherine Peterson</b>				2. Date of Death Month Day Year <b>October 2, 2000</b>		3. Time of Death <b>1652</b>	
	4a. Facility Name (If not institution, give street and number) <b>Harford Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Havre de Grace</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>196-32-8990</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>97</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 13, 1903</b>	
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>308 Paradise Road</b>		10f. Zip Code <b>21001</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Education</b>				
17. Father's Name (First, Middle, Last) <b>Pius A. Noll</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Roth</b>				
19a. Informant's Name/Relationship (Type, Print) <b>David N. Peterson (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3500 Aldino Road, Churchville, Maryland 21028</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holy Saviour Cemetery</b>		20c. Location - City or Town, State <b>10/5/00 Bethlehem, PA</b>				
21. Signature of Funeral Service Licensee <b>Hersken Amfungsbe</b>				22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. <b>pneumonia</b>				Approximate Interval Between Onset and Death <b>3 days</b>		
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <b>small bowel obstruction</b>				Due to (or as a consequence of):		
		c. _____				Due to (or as a consequence of):		
		d. _____						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Charles Eck</b>				29c. License number <b>D31712</b>		29d. Date signed (Month, Day, Year) <b>10/3/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CHARLES ECK JR 219 W. BELAIR AVE ABERDEEN, MD 21001</b>								
31. Date filed (Month, Day, Year) <b>OCT 3 - 2000</b>		32. Registrar's Signature <b>B. Sparks</b>						

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32619

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Salvatore Pinelli

2. Date of Death  
Month Day Year

SEPTEMBER 21, 2000 12:10AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

VA MARYLAND HEALTH CARE SYSTEM

4b. City, Town, or Location of Death

PERRY POINT

4c. County of Death

CECIL

5. Social Security Number

098-05-8864

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 10, 1922

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5609 Winthrop Avenue

10f. Zip Code

21214

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Automotive

17. Father's Name (First, Middle, Last)

Santo Pinelli

18. Mother's Name (First, Middle, Maiden Surname)

Frances Carro

19a. Informant's Name/Relationship (Type, Print)

Mrs. Nancy Tur (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9417 Kilbride Ct., Perry Hall, MD 21128

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Green Mount Crematory

Date

9/22/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Amanda Kelly

22. Name and Address of Facility

Schimunek Funeral Home, Inc.

9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Pinelli

29c. License number

D39170

29d. Date signed (Month, Day, Year)

SEPTEMBER 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAKESH MATHUR, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MARYLAND 21902

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

B. Spahr

State  
Registrar

NAME KNOWN TO PHYSICIAN: PINELLI, SALVATORE

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32620

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Annabell Pearson Pinder				2. Date of Death Month Day Year September 29, 2000		3. Time of Death 12:05p.m.										
	4a. Facility Name (If not institution, give street and number) 113 Charles Street Apt. 1-B				4b. City, Town, or Location of Death Sudlersville		4c. County of Death Queen Anne's										
Funeral Director	5. Social Security Number 220-34-9472	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) January 15, 1919		9. Birthplace (State or Foreign Country) Blanco, Delaware									
	Usual Residence of Decedent																
To Be Completed by Funeral Director	10a. State Maryland	10b. County Queen Anne's	10c. City, Town or Location Sudlersville			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No											
	10e. Street and Number 113 Charles Street, Apt. 1-B				10f. Zip Code 21668		10g. Citizen of What Country? USA										
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales Clerk			16b. Kind of Business/Industry Retail											
	17. Father's Name (First, Middle, Last) George W. Pearson				18. Mother's Name (First, Middle, Maiden Surname) Katie Ellingsworth												
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Robert W. Pinder/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25609 Goldsboro Road, Henderson, Maryland 21640												
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Sudlersville Cemetery		20c. Location - City or Town, State Sudlersville, Maryland		20d. Date 10/4/2000										
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 370 W. Cypress Street, Millington, Maryland 21651												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Sudden Cardiac Death</i></td> <td rowspan="4">Approximate Interval Between Onset and Death <i>seconds</i></td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. <i>Coronary Artery Disease</i></td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td rowspan="2">2 years</td> </tr> <tr> <td>d.</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <i>Sudden Cardiac Death</i>	Approximate Interval Between Onset and Death <i>seconds</i>	Due to (or as a consequence of):	b. <i>Coronary Artery Disease</i>	Due to (or as a consequence of):	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	2 years
Immediate Cause (Final disease or condition resulting in death)	a. <i>Sudden Cardiac Death</i>	Approximate Interval Between Onset and Death <i>seconds</i>															
	Due to (or as a consequence of):																
	b. <i>Coronary Artery Disease</i>																
	Due to (or as a consequence of):																
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	2 years															
	d.																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus; Hypertension</i>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred									
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. Signature and title of certifier <i>George M. Young MD</i>				29c. License number D31979		29d. Date signed (Month, Day, Year) 10/03/2000											
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GEORGE M. YOUNG MD 100 BROWN ST CHESTERTOWN, MD 21620																	
31. Date filed (Month, Day, Year) OCT 3 2000		32. Registrar's Signature <i>[Signature]</i>															

100 8 5000

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State of Maryland / Department of Health and Mental Hygiene 00 32621

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Paniere				2. Date of Death Month Day Year September 24, 2000		3. Time of Death 0958	
	4a. Facility Name (If not institution, give street and number) Kent & Queen Anne's Hospital				4b. City, Town, or Location of Death Chestertown		4c. County of Death Kent	
Funeral Director	5. Social Security Number 221-14-9239		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) February 22, 1907	
	9. Birthplace (State or Foreign Country) Nokomis, Illinois							
Usual Residence of Decedent								
10a. State Maryland		10b. County Queen Anne's		10c. City, Town or Location Marydel			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 1913 Peters Corner Road				10f. Zip Code 21649		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer			16b. Kind of Business/Industry Agriculture	
17. Father's Name (First, Middle, Last) Marco Paniere				18. Mother's Name (First, Middle, Maiden Surname) Anna Magnino Prino				
19a. Informant's Name/Relationship (Type, Print) Annabelle Taylor/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1913 Peters Corner Road, Marydel, MD 21649				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Sudlersville Cemetery		Date 9/27/2000		20c. Location - City or Town, State Sudlersville, MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 370 W. Cypress Street, Millington, Maryland 21651				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		e. <u>Pneumonitis</u> 12 hrs.						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):						
		b. <u>Chronic obstructive lung disease exacerbation</u> 3 days						
		Due to (or as a consequence of):						
		c. <u>Malnutrition</u> 3 months						
		Due to (or as a consequence of):						
		d. <u>Dehydration</u> 2 weeks						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier  M.D.			29c. License number D0051735			29d. Date signed (Month, Day, Year) 9/26/00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Frederick Delboy 6602 Church Hill Road, Suite 200, Chestertown Maryland 21620								
31. Date filed (Month, Day, Year) SEP 26 2000			32. Registrar's Signature 					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32622

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Proud

2. Date of Death  
Month Day Year

September 28, 2000

3. Time of Death

4:40 pm

4a. Facility Name (If not institution, give street and number)

Magnolia Hall Nursing Center

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral  
Director

5. Social Security Number

183-01-3640

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

107 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 23, 1893

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Chestertown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

200 Morgnec Rd

10f. Zip Code

21620

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8 yrs

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Office Worker

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Granville H. Sheip

18. Mother's Name (First, Middle, Maiden Surname)

Emma Miller

19a. Informant's Name/Relationship (Type, Print)

Howard L. Harvey (Nephew in law)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 281 Millington, Md. 21651

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Zion Cemetery

Date

10/6/00

20c. Location - City or Town, State

Porchtown, NJ

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fellows, Helfenbein &amp; Newnam Funeral Home

370 W. Cypress St. Millington, Md. 21651

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic cardiovascular disease y/r.s.  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D16488

29d. Date signed (Month, Day, Year)

9/29/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Wayne D Benjamin MD, Chestertown MD 21620

31. Date filed (Month, Day, Year)

OCT - 2 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended #1, 10/04/00, Tm, Kent County State of Maryland / Department of Health and Mental Hygiene

00 32623

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alice Mary Elizabeth Pickrell</b>				2. Date of Death Month Day Year <b>September 25, 2000</b>		3. Time of Death <b>9:47 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>142 Longfellow Drive</b>				4b. City, Town, or Location of Death <b>Chestertown</b>		4c. County of Death <b>Queen Anne's</b>	
Funeral Director	5. Social Security Number <b>199-54-7096</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 20, 1920</b>	
	9. Birthplace (State or Foreign Country) <b>Spring Brook, PA</b>		10a. State <b>Maryland</b>		10b. County <b>Queen Anne's</b>		10c. City, Town or Location <b>Chestertown</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>142 Longfellow Drive</b>		10f. Zip Code <b>21620</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own home</b>			
	17. Father's Name (First, Middle, Last) <b>Ernest Benjamin</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Nettie Ransom</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Charlotte Shrom/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>142 Longfellow Drive, Chestertown, MD 21620</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Spring Brook Cemetery</b>		Date <b>10/02/2000</b>		20c. Location - City or Town, State <b>Moscow, PA</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Mary B. Fellows</b>				22. Name and Address of Facility <b>Fellows, Helfenbein &amp; Newnam Funeral Home. P.A. 130 Speer Road, Chestertown, Maryland 21620</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Colon Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death <b>3 months</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CAD<sub>3</sub> / MI 4/2000 / HTN / PVD<sub>3</sub> / DVT / COPD / ↑ Chol / Hx GI Bleed / Hypothyroid / Renal Insufficiency</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <b>Neil Stoddard MD</b>				29c. License number <b>D50996</b>		29d. Date signed (Month, Day, Year) <b>9/25/00</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Neil Stoddard MD 100 Brown St. Chestertown MD 21620</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>SEP 26 2000</b>				32. Registrar's Signature <b>B. Sparks</b>			



James William Phillips

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32624

Amend Item #5, per FH 10/02/2000 BG

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Weldon Phillips</b>		2. Date of Death Month Day Year <b>September 29, 2000</b>		3. Time of Death <b>8:08 P.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>Peninsula Reional Medical Center</b>		4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>
Funeral Director	5. Social Security Number <b>240-18-1623</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>06/22/1922</b>	9. Birthplace (State or Foreign Country) <b>Georgia</b>
	Usual Residence of Decedent				
10a. State <b>MD</b>		10b. County <b>Somerset</b>		10c. City, Town or Location <b>Princess Anne</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>12140 Drawbridge Road</b>		10f. Zip Code <b>21853</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>none</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Receiver</b>		16b. Kind of Business/Industry <b>Grocery Store</b>		17. Father's Name (First, Middle, Last) <b>Webb Weldon</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Hazel Ingram</b>		19a. Informant's Name/Relationship (Type, Print) <b>Sue Phillips/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12140 Drawbridge Road, Princess Anne, Md. 21853</b>	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		20c. Location - City or Town, State <b>10/01/00 Salisbury, Md.</b>	
21. Signature of Funeral Service Licensee <i>James L. Hinman</i> M00295		22. Name and Address of Facility <b>Hinman Funeral Home</b> <b>11673 Somerset Ave., Princess Anne, Md. 21853</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <i>Drowning</i></b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. <i>Due to (or as a consequence of):</i></b> <b>c. <i>Due to (or as a consequence of):</i></b> <b>d. <i>Due to (or as a consequence of):</i></b>		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Final 9/29/00 1905 HME</b>		28b. Time of Injury <b>1905 HME</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>City of Channel</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>12140 Drawbridge Road, Princess Anne, Maryland</b>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Theodore M. King</i>		29c. License number <b>O.C.M.E.</b>	
29d. Date signed (Month, Day, Year) <b>September 30, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>THEODORE M. KING</b>		31. Data filed (Month, Day, Year) <b>OCT 02 2000</b>	
32. Registrar's Signature <i>Benjamin G. Sparks</i>					

Baltimore, Maryland 21215-0020

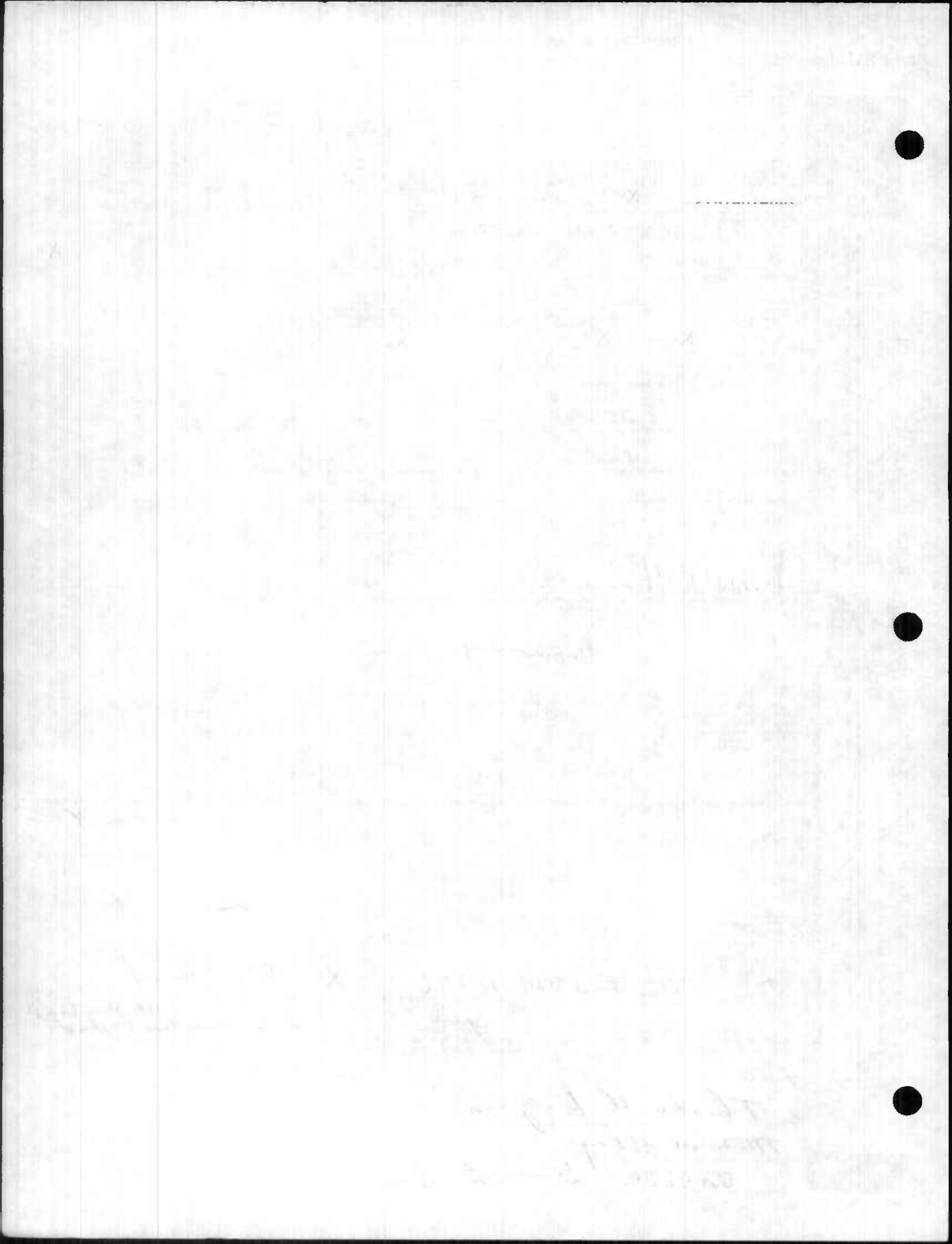
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32625

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eugene Kemp Pritts, Sr.

2. Date of Death

Month Day Year  
Sept. 18, 2000

3. Time of Death

14:38

4a. Facility Name (If not institution, give street and number)

Garrett County Memorial Hospital

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

Funeral  
Director

5. Social Security Number

214--28-7162

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Montha Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 28, 1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Oakland

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2973 Fingerboard Road

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 52-54

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

18a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Harry Daniel Pritts

18. Mother's Name (First, Middle, Maiden Surname)

Lena Virginia Wright

19a. Informant's Name/Relationship (Type, Print)

Dottie L. Pritts/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2973 Fingerboard Road, Oakland, Md. 21550

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Georg Cemetery

Date

9/21/00

20c. Location - City or Town, State

Swanton, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stewart Funeral Home

32 S. Second St., Oakland, Md. 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

lung carcinoma

Approximate Interval Between Onset and Death

4 months

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pneumonia

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician  
2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D23979

29d. Date signed (Month, Day, Year)

9-19-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert A. Goralski, M.D. 311 N. Fourth St Oakland, MD 21550

31. Date filed (Month, Day, Year)

SEP 20 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32626

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nettie Mabel Peck

2. Date of Death

Month Day Year  
SEPT. 21, 2000

3. Time of Death

1:30 PM

4a. Facility Name (If not institution, give street and number)

Western Maryland Hospital Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

218-70-1292

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 30, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Garrett

10c. City, Town or Location

Mt. Lake Park

10d. Inside City Limits

☒ Yes ☐ No

10a. Street and Number

701 I Street

10f. Zip Code

21550

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

William Henry Speicher

18. Mother's Name (First, Middle, Maiden Surname)

Missouri Belle Nine

19a. Informant's Name/Relationship (Type, Print)

Donald C. Peck/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

210 Barnard St., Frostburg, Md. 21532

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Paradise Cemetery

Date

9/25/00

20c. Location - City or Town, State

Deer Park, Md.

21. Signature of Funeral Service Licensee

► Bradley H. Stewart

22. Name and Address of Facility

Stewart Funeral Home

32 S. Second St., Oakland, Md. 21550

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Hypertensive Heart Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

weeks

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Respiratory Failure, Ventilator Dependent  
Chronic Renal Insufficiency

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ NoHospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► Rose Marie Chan, M.D.

29c. License number

D76416

29d. Date signed (Month, Day, Year)

Sept. 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rose Marie Chan, M.D.

1500 Pennsylvania Avenue

Hagerstown, MD 21742

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

► [Signature]

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #23 PART I, PER PHY G787 9-25-00 WR.

Certificate of Death

Reg. No. 00 32627

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Jacqueline Rusch Pfaus</b>		2. Date of Death Month Day Year <b>August 17, 2000</b>		3. Time of Death <b>6:00PM</b>	
4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>			4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>
5. Social Security Number <b>388-22-8715</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 21, 1926</b>
9. Birthplace (State or Foreign Country) <b>Wisconsin</b>					
Usual Residence of Decedent					
10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Kensington</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>10810 St. Paul Street</b>		10f. Zip Code <b>20895</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Public Schools</b>	
17. Father's Name (First, Middle, Last) <b>Milton H. Rusch</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Doris T. Mott</b>		
19a. Informant's Name/Relationship (Type, Print) <b>James G. Pfaus/Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10810 St. Paul Street, Kensington, MD 20895</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>	
21. Signature of Funeral Service Licensee <b>David E. Perry</b> M00803		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>RESPIRATORY FAILURE</b> <b>Respiratory Failure with Possible Aspiration</b> <b>PNEUMONIA</b> <b>Clostridium Difficile Colitis</b> <b>CLOSTRIDIUM DIFFICILE COLITIS</b> <b>Crest Syndrome</b> <b>CREST HYNDROME</b>					Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>David E. Perry, MD</b>		29c. License number <b>D0054566</b>		29d. Date signed (Month, Day, Year) <b>August 18, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sunitha Bhogavilli, 8609 2nd Avenue, Suite 404B, Silver Spring, MD 20910</b>					
31. Date filed (Month, Day, Year) <b>AUG 21 2000</b>		32. Registrar's Signature <b>Benjamin B. Sparks</b>			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32628

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RUTH Allene RAY</b>		2. Date of Death Month <b>OCTOBER</b> Day <b>1</b> Year <b>2000</b>		3. Time of Death <b>15:16</b>
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>City</b>
Funeral Director	5. Social Security Number <b>225-36-3023</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>July 16, 1930</b>		9. Birthplace (State or Foreign Country) <b>Kentucky</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>97 Smith Avenue</b>			10f. Zip Code <b>21001</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>In home</b>	
17. Father's Name (First, Middle, Last) <b>Kermit Hartsock</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Katherine Bowling</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Reed Ray (Husband)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>97 Smith Avenue, Aberdeen, Maryland 21001</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Grove Presbyterian Cemet.</b>		20c. Location - City or Town, State <b>Aberdeen, Maryland</b>	
20d. Date <b>10/5/00</b>					
21. Signature of Funeral Service Licensee <b>Kirkon Amy Unglesbee</b>		22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death <b>5 YEARS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>David Zarr, MD</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>OCTOBER 1, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAVID ZAAS, MD, JOHNS HOPKINS, 600 WOLFE, BALTIMORE, MARYLAND 21287</b>					
31. Date filed (Month, Day, Year) <b>OCT 1 - 2000</b>		32. Registrar's Signature <b>B. Sparks</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32629

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NANCY IDA RYNES

2. Date of Death

Month Day Year  
SEPT 23, 2000

3. Time of Death

16=4040

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2504 ROY TERRACE

4b. City, Town, or Location of Death

FALLSTON

4c. County of Death

HARFORD

5. Social Security Number

214-38-4332

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

SEPT. 23, 1940

9. Birthplace (State or Foreign)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2504 Roy Terrace

10f. Zip Code

21047

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frederick Baldauf

18. Mother's Name (First, Middle, Maiden Surname)

Betty Oppelt

19a. Informant's Name/Relationship (Type, Print)

Thomas I. Rynes Sr. (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2504 Roy Terrace, Fallston, MD 21047

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Highview Memorial Gardens

Date

9/26/00

20c. Location - City or Town, State

Fallston, Maryland

21. Signature of Funeral Service Licensee

Christina L. David

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.  
610 W. MacPhail Road, Bel Air, MD 2101423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

ASCVD

a. Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

DME

29c. License number

OCME

29d. Date signed (Month, Day, Year)

SEPT 23, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GSPHABHU MD 728 BELAIR MD BELAIR MD 21014

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32630

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clemens

August

Riley

2. Date of Death

Month

Day

Year

October

1

2000

3. Time of Death

1:15 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Crofton Convalescent Center

4b. City, Town, or Location of Death

Crofton

4c. County of Death

Anne Arundel

5. Social Security Number

495-24-1987

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 23, 1930

9. Birthplace (State or Foreign Country)

MO

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3465 A Marigold Pl.

10f. Zip Code

20602

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year of Discharge

1950-1972

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Lt. Colonel

16b. Kind of Business/Industry

U.S. Army

17. Father's Name (First, Middle, Last)

Charles D. Riley

18. Mother's Name (First, Middle, Maiden Surname)

Anna Splisgardt Riley

19a. Informant's Name/Relationship (Type, Print)

Shawn C. Riley/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12503 Knowledge Lane Bowie, Md. 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cem. 10/17/00 Arlington, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

David C. Cho

MO0945

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, P.A.

P.O. Box 567 LaPlata, MD 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Heart Disease

years

Due to (or as a consequence of):

b. Parkinson's Disease

years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Multiple Decubitus ulcer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rakesh Arora MD

29c. License number

D20108

29d. Date signed (Month, Day, Year)

10/2/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAKESH ARORA, M.D. 14300 Gallant Fox Ln. #202 Bowie, MD.

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 05 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 0005.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32631

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANN MARIE REZAC				2. Date of Death Month Day Year OCTOBER 8, 2000				3. Time of Death 5:15 AM	
	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center				4b. City, Town, or Location of Death Towson				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-46-7664		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 55		8. Date of Birth (Month, Day, Year) 7-14-45		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore County				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 119 West Elm Avenue				10f. Zip Code 21206				10g. Citizen of What Country? USA		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry Legal Industry		
17. Father's Name (First, Middle, Last) Ervin K. Rezac					18. Mother's Name (First, Middle, Maiden Surname) Theresa E. Dunnigan					
19a. Informant's Name/Relationship (Type, Print) Theresa Ann Hobbs					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3035 Cascade Dr. Abingdon, Maryland 21009					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		Date 10-10-00		20c. Location - City or Town, State Baltimore, Md.		
21. Signature of Funeral Service Licensee <i>Donald C. Gassman</i>					22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) METASTATIC BREAST CANCER  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>Joginder P. Mehta M.D.</i>					29c. License number D0041410			29d. Date signed (Month, Day, Year) October 8th, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P. MEHTA M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204										
State Registrar		31. Date filed (Month, Day, Year) OCT 16 2000		32. Registrar's Signature <i>Benjamin B. Sparks</i>						

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32632

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harvey Ralph RUGH

2. Date of Death

September 22, 2000

3. Time of Death

10:15 AM

4a. Facility Name (If not institution, give street and number)

Garrett County Memorial Hospital

4b. City, Town, or Location of Death

Oakland

4c. County of Death

Garrett

Funeral  
Director

5. Social Security Number

169-01-4606

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Oct. 27, 1914

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

PA

10b. County

Allegheny

10c. City, Town or Location

Oakmont

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

223 Washington Ave.

10f. Zip Code

15139

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steelworker

16b. Kind of Business/Industry

Steel Production

17. Father's Name (First, Middle, Last)

Harvey

Rugh

18. Mother's Name (First, Middle, Maiden Surname)

Mary

Remaley

19a. Informant's Name/Relationship (Type, Print)

Kathleen Peterson/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2105 Mosser Road, McHenry, MD 21541

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Calvary Cemetery

Date

9/26/00

20c. Location - City or Town, State

Pittsburgh, PA

21. Signature of Funeral Service Licensee

Bridget A. ...

22. Name and Address of Facility

Stewart Funeral Home  
32 S. Second St., Oakland, MD 21550Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Approximate Interval Between Onset and Death

Immediate

Due to (or as a consequence of):

b. ASHD-Chronic

Years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peptic Ulcer Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Thomas Johnson

29c. License number

D15333

29d. Date signed (Month, Day, Year)

9/22/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Thomas Johnson, MD 311 N. Fourth St., Oakland, Maryland 21550

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 25 2000

32. Registrar's Signature

B. ...

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32633

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sally Janiak Rosemont

2. Date of Death

Month Day Year  
Sept 9 2000

3. Time of Death

7:40PM

4a. Facility Name (If not institution, give street and number)

St Mary's Nursing Center

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St Mary's

Funeral  
Director

5. Social Security Number

304 12 9220

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Nov 14 1912

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Md

10b. County

St Mary's

10c. City, Town or Location

Leonardtown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

21585 Peabody Street

10f. Zip Code

20650

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10thCollege (1-4or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Musician

16b. Kind of Business/Industry

Music

17. Father's Name (First, Middle, Last)

Antony Janiak

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Kazoyed

19a. Informant's Name/Relationship (Type, Print)

Henry Rosemont Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20058 Havirland Ct., Lexington Park, Md 20653

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Geo. Washington Univ.

Date

Sept 9  
2000

20c. Location - City or Town, State

Washington DC

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Columbia Mortuary Services P.O. Box 58007  
Washington DC 2003723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

Failure of major organ systems

3 weeks

a. Due to (or as a consequence of):

Heart Failure

8 weeks

b. Due to (or as a consequence of):

Atherosclerotic hypertension

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

29c. License number

DO-2159

29d. Date signed (Month, Day, Year)

September 18, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugene Guazzo, M.D. Maryland Infirmery, Chaptico, MD 20621-0002

State  
Registrar

31. Date filed (Month, Day, Year)

SEP 27 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

RECEIVED

SEP 25 2000

ST. MARY'S CO.  
HEALTH DEPARTMENT



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32634

Amend Items 325, 27, 28a-f per MEOG 795 5/2/01 EW

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Linda Ann Petras Reiher						2. Date of Death Month Day Year September 8, 2000			3. Time of Death 6:45 p.m.	
	4a. Facility Name (If not institution, give street and number) Bayside Care Center						4b. City, Town, or Location of Death Lexington Park			4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 432-94-4032		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 7, 1948		9. Birthplace (State or Foreign Country) California		
	Usual Residence of Decedent										
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Lexington Park				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 21412 Great Mills Road				10f. Zip Code 20653			10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Personnel Specialist				16b. Kind of Business/Industry Dept. of the Navy			
17. Father's Name (First, Middle, Last) Raymond Kelling						18. Mother's Name (First, Middle, Maiden Surname) Lee Ann (unknown)					
19a. Informant's Name/Relationship (Type, Print) Richard A. Reiher / Husband						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2572 Ocean Gateway, Trappe, Maryland 21673					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Crematory Brinsfield-Echols			20c. Location - City or Town, State 9-10-00 Charlotte Hall, Maryland				
21. Signature of Funeral Service Licensee Edward N. Brinsfield, Jr.						22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Acute upper gastric intestinal hemorrhage</i> Due to (or as a consequence of): b. <i>Gastric ulcer</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Traumatic Brain Injury (old)</i> <i>Seizure Disorder</i> <i>quadruplegia</i>											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accidental 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 11-27-89		28b. Time of Injury Unknown AM		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred Subject fell backwards down a flight of steps			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Apartment Complex				28f. Location (Street and Number or Rural Route Number, City or Town, State) Fajardo, Puerto Rico					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <i>[Signature]</i>						29c. License number D19917		29d. Date signed (Month, Day, Year) 9/11/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James C. Boyd, M.D., 23415 Three Notch Road, California, Maryland 20619											
31. Date filed (Month, Day, Year) SEP 14 2000		32. Registrar's Signature <i>[Signature]</i>									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32635

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Beatrice Marie Saylor				2. Date of Death Month Day Year September 28 2000				3. Time of Death 7:10 PM	
	4a. Facility Name (If not institution, give street and number) 10955 Green Valley Rd.				4b. City, Town, or Location of Death Union Bridge				4c. County of Death Frederick	
Funeral Director	5. Social Security Number 212-38-7708		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) March 3, 1909		9. Birthplace (State or Foreign Country) Washington DC		10a. State MD		10b. County Frederick		10c. City, Town or Location Union Bridge	
Usual Residence of Decedent		10d. inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 10955 Green Valley Rd.		10f. Zip Code 21791		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) teacher		16b. Kind of Business/Industry public school				
17. Father's Name (First, Middle, Last) Clarence Diehl				18. Mother's Name (First, Middle, Maiden Surname) Lena Metcalfe						
19a. Informant's Name/Relationship (Type, Print) S. Herman Saylor - husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10955 Green Valley Rd., Union Bridge, MD 21791						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Johnsville Meth. Cemetery		Date Oct. 2		20c. Location - City or Town, State Union Bridge, MD				
21. Signature of Funeral Service Licensee Catherine O. Hartzler		22. Name and Address of Facility Hartzler Funeral Home 6 E. Broadway, Union Bridge, MD								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Recurrent thrombotic stroke Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d.						Approximate interval Between Onset and Death Oct. '97 YRS.				
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Osteoporosis						23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier J. H. Caricape MD		29c. License number DD000906		29d. Date signed (Month, Day, Year) 9/29/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. H. Caricape MD 104 N Main, Union Bridge MD 21791										
31. Date filed (Month, Day, Year) OCT 03 2000		32. Registrar's Signature B Sparks								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32636

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Anna L. Savage					2. Date of Death Month Day Year September 26, 2000			3. Time of Death 2:40 AM	
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare - Loch Raven					4b. City, Town, or Location of Death Baltimore			4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-22-8845		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Dec. 31, 1903		9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Perry Hall	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 18 Gunview Farm Ct.		10f. Zip Code 21128		10g. Citizen of What Country? U.S.A.		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker	
To Be Completed by Physician/Medical Examiner	15b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) John Wernsdorfer		18. Mother's Name (First, Middle, Maiden Surname) Kate Baker		19a. Informant's Name/Relationship (Type, Print) John Birkmaier (Grand-son)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Gunview Farm Ct., Perry Hall, MD 21128	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery		Date 9/30/00		20c. Location - City or Town, State Baltimore, Maryland		21. Signature of Funeral Service Licensee 	
Physician /Medical Examiner	22. Name and Address of Facility Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Sepsis</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death less than one week		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D30661		29d. Date signed (Month, Day, Year) September 29, 2000	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sireesh TRIPURAWANI 5601 Loch Raven Blvd. Baltimore, Md - 21239.		31. Date filed (Month, Day, Year) SEP 29 2000		32. Registrar's Signature 		33. Date of Death SEP 26 2000		34. Time of Death 2:40 AM	





1:50 p.m.  
September 22, 2000  
Seidel, Meyer

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32637

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Meyer Seidel</b>		2. Date of Death Month <b>September</b> Day <b>22</b> Year <b>2000</b>		3. Time of Death <b>1:50 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Gilchrist Center</b>		4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>213-14-0786</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months <b>0</b> Days <b>0</b>	If Under 24 Hrs. Hours <b>0</b> Min. <b>0</b>	8. Date of Birth (Month, Day, Year) <b>Sept. 10, 1915</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent						
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1371 Walker Ave.</b>				10f. Zip Code <b>21239</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>8th Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Business Owner</b>		16b. Kind of Business/Industry <b>Self-Employed Package Goods</b>			
17. Father's Name (First, Middle, Last) <b>Philip Seidel</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Sevelovitz</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Patricia Bushell (daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1101 Malkus Way, Bel Air, MD 21014</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem.</b>		Date <b>9/27/00</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Brian A. Willen</b>		22. Name and Address of Facility <b>Schimunek Funeral Home, Inc.</b> <b>9705 Belair Rd., Baltimore, MD 21236</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Lung cancer</b>					Approximate Interval Between Onset and Death <b>2 months</b>	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Hospice</b>					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29s. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier <b>W.A. Riley</b>		29c. License number <b>D25205</b>		29d. Date signed (Month, Day, Year) <b>September 22, 2000</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>W.A. Riley GPMC 6701 N. Charles St - Balto. MD</b>							
31. Date filed (Month, Day, Year) <b>SEP 26 2000</b>		32. Registrar's Signature <b>B. Sparks</b>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32638

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LINDA S. SMITH</b>				2. Date of Death Month <u>September</u> Day <u>22</u> Year <u>2000</u>				3. Time of Death <u>1050 A</u>	
	4a. Facility Name (If not institution, give street and number) <b>Fallston General Hospital</b>				4b. City, Town, or Location of Death <b>Fallston</b>				4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>213-52-6893</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>52</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>2/7/1948</b>		9. Birthplace (State or Foreign Country) <b>N. Carolina</b>	
	Usual Residence of Decedent									
10a. State <b>PA</b>		10b. County <b>York</b>		10c. City, Town or Location <b>Fawn Grove</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>Box 180, Garvine Mill Rd.</b>				10f. Zip Code <b>17321</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Custodian</b>				16b. Kind of Business/Industry <b>Education</b>		
17. Father's Name (First, Middle, Last) <b>Frank Hodge</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hazel Moxley</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Dennis D. Smith- husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Box 180, Garvine Mill Rd., Fawn Grove, PA</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Mem.Gdns</b>				20c. Location - City or Town, State <b>MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Harkins F.H.Inc., 600 Main St., Delta, PA</b>				17314		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. METASTATIC ANAL CARCINOMA</b>				Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____				Approximate Interval Between Onset and Death <b>30 months</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HEPATIC FAILURE</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and Title of certifier 				29c. License number <b>D31775</b>		
				29d. Date signed (Month, Day, Year) <b>September 22, 2000</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOAN P EDWARDS MD. 2112 BLAIR RD FALLSTON MD 21047</b>										
31. Date filed (Month, Day, Year) <b>SEP 28 2000</b>				32. Registrar's Signature 						

RECEIVED BY THE DIRECTOR

RECEIVED BY THE DIRECTOR

RECEIVED BY THE DIRECTOR

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RECEIVED BY THE DIRECTOR

RECEIVED BY THE DIRECTOR

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32639

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence Edward Spires

2. Date of Death

Month Day Year  
Sept. 29, 2000

3. Time of Death

2:25 AM

4e. Facility Name (If not institution, give street and number)

Alice Byrd Tawes Nursing Home

4b. City, Town, or Location of Death

Crisfield

4c. County of Death

Somerset

Funeral  
Director

5. Social Security Number

215-20-2037

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
04/21/1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Somerset

10c. City, Town or Location

Crisfield

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

201 Hall Highway

10f. Zip Code

21817

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
11College (1-4 or 5+)  
none16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Packing Company

17. Father's Name (First, Middle, Last)

Charles Spires

18. Mother's Name (First, Middle, Maiden Surname)

Addie Elliott

19a. Informant's Name/Relationship (Type, Print)

Vicki Spires Dize/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3487 State Street, Crisfield, Md. 21817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Asbury U.M. Cemetery

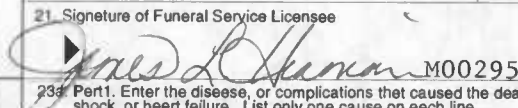
Date

10/01/00

20c. Location - City or Town, State

Crisfield, MD.

21. Signature of Funeral Service Licensee

 M00295

22. Name and Address of Facility

Hinman Funeral Home

11673 Somerset Avenue, Princess Anne, MD. 21853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

ASCD

e. Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia - Alzheimer's

Normal Pressure Hydrocephalus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

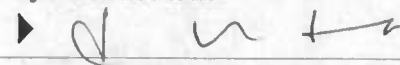
27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28e. Date of Injury  
(Month, Day Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D 48098

29d. Date signed (Month, Day, Year)

Sept. 29, 2000

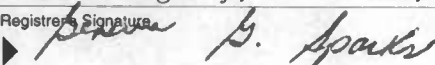
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. V. Karuminathan, 201 Hall Highway, Crisfield, Md. 21817

31. Date filed (Month, Day, Year)

OCT 02 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32640

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert William Soderberg</b>				2. Date of Death Month Day Year <b>September 10, 2000</b>		3. Time of Death <b>6:50 p.m.</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Solomons Nursing Center</b>				4b. City, Town, or Location of Death <b>Solomons</b>		4c. County of Death <b>Calvert</b>	
Funeral Director	5. Social Security Number <b>361-05-8586</b>		6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>82</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 6, 1918</b>	9. Birthplace (State or Foreign Country) <b>Illinois</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Calvert</b>	10c. City, Town or Location <b>Solomons</b>			10d. Inside City Limits <b>1 Yes 2 No</b>		
	10e. Street and Number <b>111 William Street</b>				10f. Zip Code <b>20688</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <b>2 Married</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b>		14. Race - American Indian, Black, White, etc. <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) <b>College (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Commissioned Officer</b>				16b. Kind of Business/Industry <b>US Defense</b>	
	17. Father's Name (First, Middle, Last) <b>William Evans Soderberg</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Winifred Hanlon</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Lee Norris Soderberg / Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 1644, Solomons, Maryland 20688</b>			
	20a. Method of Disposition <b>2 Cremation</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crematory</b>		20c. Location - City or Town, State <b>Charlotte Hall, MD</b>		20d. Date <b>9-12-00</b>	
	21. Signature of Funeral Service Licensee <i>Edward N. Brinsfield, Jr.</i>				22. Name and Address of Facility <b>Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Cardiac Arrhythmia</b>							Approximate Interval Between Onset and Death <b>5 minutes</b>
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Due to (or as a consequence of):</b>							
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>						26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>		
27. Manner of Death <b>1 Natural</b>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred
29a. Certifier (Check only one) <b>1 Certifying Physician</b>		29b. Signature and title of certifier <i>Charles W. Bennett M.D.</i>						
29c. License number <b>D25156</b>		29d. Date signed (Month, Day, Year) <b>September 11, 2000</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Charles W. Bennett, M.D., 11845 H.G. Trueman Road, Lusby, Maryland 20657</b>								
31. Date filed (Month, Day, Year) <b>SEP 14 2000</b>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

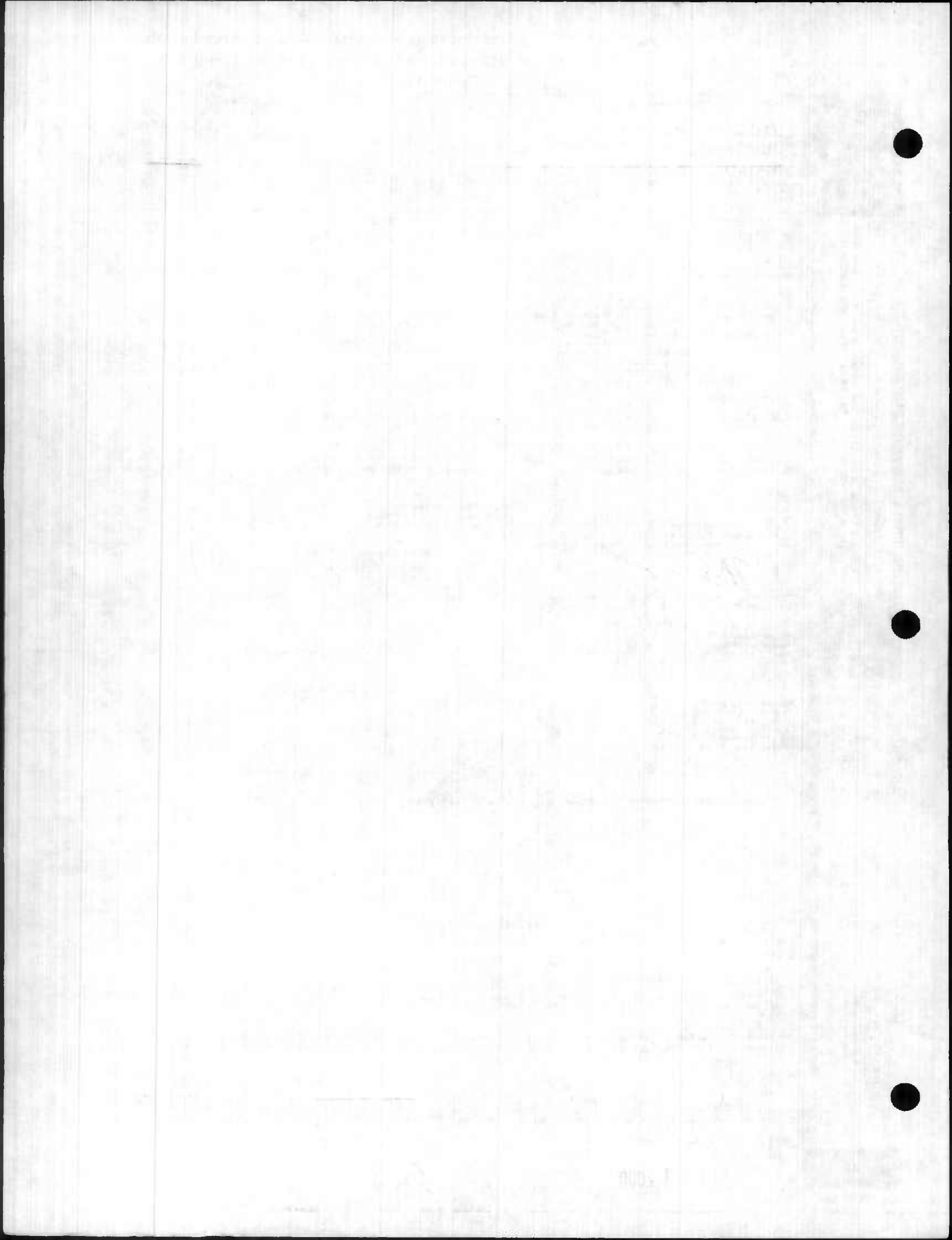
00 32641

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY ELIZABETH SOMERVILLE</b>				2. Date of Death Month <b>September</b> Day <b>9</b> Year <b>2000</b>		3. Time of Death <b>2:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>St. Mary's Nursing Center</b>				4b. City, Town, or Location of Death <b>Leonardtown</b>		4c. County of Death <b>St. Mary's</b>	
Funeral Director	5. Social Security Number <b>216-22-3694</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>10-15-13</b>		9. Birthplace (State or Foreign Country) <b>Leonardtown, MD</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>St. Mary's</b>	10c. City, Town or Location <b>Loveville</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>40445 B. Somerville Lane</b>			10f. Zip Code <b>20656</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Facility Maintenance</b>		16b. Kind of Business/Industry <b>Patuxent River Naval Air Station</b>			
	17. Father's Name (First, Middle, Last) <b>Herbert Blackistone</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rachel Swales</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Sarah Blackistone</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>26195 Loveville Rd, Mechanicsville, MD 20654</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Joseph's C.C. Cemetery</b>		Date <b>9-14-00</b>		20c. Location - City or Town, State <b>Morganza, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Strickland Funeral Services, P.A. 6500 Allentown Rd., Camp Springs, MD 20748</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cerebrovascular Accident</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>							
	Approximate Interval Between Onset and Death <b>1 1/2 months</b>							
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier  <b>SC Gabry M.D.</b>				29c. License number <b>D54346</b>		29d. Date signed (Month, Day, Year) <b>9-11-00</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>C. Sajja, M.D. 24035 Three Knotch Rd. Hollywood, MD</b>							
31. Date filed (Month, Day, Year) <b>SEP 18 2000</b>		32. Registrar's Signature 						

ORIGINAL

W. B. 100

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ADDIE STULL		2. Date of Death Month Day Year 09 18 2000		3. Time of Death 03:52 AM	
	4a. Facility Name (If not institution, give street and number) University of Maryland Medical System <del>UNIVERSITY OF MARYLAND HOSPITAL</del>		4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death <del>CITY</del> N/A	
Funeral Director	5. Social Security Number 219-20-3378		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 97 Yrs.	
	8. Date of Birth (Month, Day, Year) 12/5/1902		9. Birthplace (State or Foreign Country) MARYLAND			
To Be Completed by Funeral Director	Usual Residence of Decedent					
	10a. State MD.		10b. County CARROLL		10c. City, Town or Location WESTMINSTER	
	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	10e. Street and Number 45 S. CHURCH ST.		10f. Zip Code 21157		10g. Citizen of What Country? USA.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: WHITE					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		16b. Kind of Business/Industry HOME MAKER	
	17. Father's Name (First, Middle, Last) SYLVESTER WATKINS		18. Mother's Name (First, Middle, Maiden Surname) ESTELLE BUXTON			
	19a. Informant's Name/Relationship (Type, Print) LOIS FORD - DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 441 BANKARD RD., WESTMINSTER, MD. 21158			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MEADOW BRANCH CEM.		20c. Location - City or Town, State 9/20/00 WESTMINSTER, MD.	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. BILATERAL PLEURAL EFFUSIONS Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
Medical Certification: To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	29b. Signature and title of certifier 		29c. License number P14666		29d. Date signed (Month, Day, Year) 09/18/2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL SACK 22 S. GREENE ST BALTIMORE, MD 21201					
	State Registrar	31. Date filed (Month, Day, Year) SEP 21 2000		32. Registrar's Signature 		





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32643

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Bernice Elaine Taylor				2. Date of Death Month: 9 Day: 29 Year: 00		3. Time of Death 8:00 PM	
	4a. Facility Name (If not institution, give street and number) Carroll County General Hospital				4b. City, Town, or Location of Death Westminster		4c. County of Death Carroll	
Funeral Director	5. Social Security Number 213-24-8993		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) Aug 15 1929	
	9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County Carroll		10c. City, Town or Location Westminster	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 182 East Green Street		10f. Zip Code 21157		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Child Care Provider		16b. Kind of Business/Industry United Methodist Church			
	17. Father's Name (First, Middle, Last) Robert Poole				18. Mother's Name (First, Middle, Maiden Surname) Mildred Mancha			
	19a. Informant's Name/Relationship (Type, Print) Susan Bare/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 1001 N. Randolph St Arlington, VA 22201 220			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Westminster Cemetery		20c. Date 10/3		20d. Location - City or Town, State Westminster, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIOGENIC SHOCK b. MYOCARDIAL INFARCTION c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MULTIPLE SCLEROSIS HYPERGLYCEMIA							
	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier 				29c. License number MD 00046502		29d. Date signed (Month, Day, Year) 9/29/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew B. BAWSTAN - Carroll County General Hospital, 200 Memorial Ave.							
31. Date filed (Month, Day, Year) OCT 03 2000		32. Registrar's Signature 						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32644

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Pauline Norman Taylor</b>				2. Date of Death Month Day Year <b>September 29, 2000</b>				3. Time of Death <b>11:50 PM</b>				
	4a. Facility Name (If not institution, give street and number) <b>Citizens Nursing Home</b>				4b. City, Town, or Location of Death <b>Havre De Grace</b>				4c. County of Death <b>Harford</b>				
Funeral Director	5. Social Security Number <b>215-40-0186</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>95</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>01/14/1905</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>												
Usual Residence of Decedent													
10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>						10d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>738 Nottingham Drive</b>				10f. Zip Code <b>21001</b>				10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Home</b>					
17. Father's Name (First, Middle, Last) <b>Ernest Norman</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Margaret Johnson</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Norma Burke- Daughter</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>738 Nottingham Dr., Aberdeen, MD 21001</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Angel Hill Cemetery</b>				Date <b>10/3/00</b>		20c. Location - City or Town, State <b>Havre de Grace, MD</b>			
21. Signature of Funeral Service Licensee <b>Dwaine M. Smith</b>						22. Name and Address of Facility <b>Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, MD 21078</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) e. <b>PANCREATIC CARCINOMA</b> Due to (or as a consequence of):													
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b> Due to (or as a consequence of):													
c. Due to (or as a consequence of):													
d. Due to (or as a consequence of):													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>History of Bilateral Ovarian Stone with STARS post</b> <b>Spontaneous Pneumonia</b> <b>Anemia</b>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier <b>Dwaine M. Smith MD</b>						29c. License number <b>046412</b>			29d. Date signed (Month, Day, Year) <b>10/4/00</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dwaine M. Smith 379 S. Union Ave Hdg MD 21078</b>													
31. Date filed (Month, Day, Year) <b>OCT 3 - 2000</b>				32. Registrar's Signature <b>[Signature]</b>									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
Taylor, Pauline N.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32645

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Betty Tedrow</b>				2. Date of Death Month <b>09</b> Day <b>25</b> Year <b>2000</b>				3. Time of Death <b>0615</b>		
	4a. Facility Name (If not institution, give street and number) <b>Manor Care Rossville</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>217-64-1550</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) <b>03/12/21</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>		10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>		
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>715 Shirley Drive</b>				10f. Zip Code <b>21001</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>In home</b>				
	17. Father's Name (First, Middle, Last) <b>Willis O. Todd</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Courtright</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>Wayne B. Tedrow (Spouse)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>715 Shirley Drive Aberdeen, Maryland 21001</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harford Memorial Gardens</b>		Date <b>9/28/00</b>		20c. Location - City or Town, State <b>Aberdeen, Maryland</b>				
	21. Signature of Funeral Service Licensee <b>Kenneth B. Baugh</b>				22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cerebrovascular Accident</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Chronic Glomerulonephritic Peripheral Vascular Disease</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>				Approximate Interval Between Onset and Death <b>7 days</b>						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>End stage renal disease</b> <b>Chronic Glomerulonephritic</b> <b>Peripheral Vascular Disease</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown						
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Deborah L. Giallo</b>		29c. License number <b>110055992</b>		29d. Date signed (Month, Day, Year) <b>09/25/00</b>					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Deborah L Giallo DO 6730 Holabird Ave Baltimore, MD 21222</b>				31. Date filed (Month, Day, Year) <b>SEP 27 2000</b>				32. Registrar's Signature <b>B. Sparks</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32646

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLOTTE ELEANOR ESTEP THOMAS				2. Date of Death Month Day Year October 2, 2000		3. Time of Death 11:45 A.M.	
	4a. Facility Name (If not institution, give street and number) Civista Medical Center				4b. City, Town, or Location of Death La Plata		4c. County of Death Charles	
Funeral Director	5. Social Security Number 219-42-3652	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 56	8. Date of Birth (Month, Day, Year) FEB. 23, 1944	9. Birthplace (State or Foreign Country) MARYLAND			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County CHARLES		10c. City, Town or Location NEWBURG		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 13535 PICCOWAXEN CREEK ROAD				10f. Zip Code 20664		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 YEARS		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PROGRAM COORDINATOR		16b. Kind of Business/Industry CHARLES COUNTY ASSN. OF HANDICAP & RETARDATION			
	17. Father's Name (First, Middle, Last) CHARLES ESTEP				18. Mother's Name (First, Middle, Maiden Surname) RUTH ELEANOR JOHNSON ESTEP			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) JOHN HENRY THOMAS / HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13535 PICCOWAXEN CREEK ROAD, NEWBURG, MARYLAND 20664			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SHILOH CHURCH CEMETERY		20c. Location - City or Town, State NEWBURG, MARYLAND		20d. Date 10/6/00	
	21. Signature of Funeral Service Licensee Lidia C. Thornton Johnson		22. Name and Address of Facility THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Lung cancer Due to (or as a consequence of): b. Tobacco use Due to (or as a consequence of): c. Lung metastasis Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death 1 yr 35 yrs							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation, COPD Lung pleural effusion.				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Lidia C. Thornton Johnson		29c. License number D - 0008370		29d. Date signed (Month, Day, Year) 10-2-2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul E. Pritchett, MD. 118 LaGrange Ave. P.O.Box 1317 La Plata, MD. 20646								
31. Date filed (Month, Day, Year) OCT 05 2000		32. Registrar's Signature B. Sparks						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32647

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Nellie Tichnell</b>				2. Date of Death Month Day Year <b>SEPTEMBER 27 2000</b>				3. Time of Death <b>11:02AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Sacred Heart Hospital</b>				4b. City, Town, or Location of Death <b>Cumberland</b>				4c. County of Death <b>Allegany</b>	
Funeral Director	5. Social Security Number <b>220-76-9177</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 4, 1910</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>Garrett</b>		10c. City, Town or Location <b>Swanton</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>2151 Chestnut Grove Road</b>				10f. Zip Code <b>21561</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Housework</b>			
	17. Father's Name (First, Middle, Last) <b>Arnold Shreve</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Miranda Sears</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Jerry Tichnell/ son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16472 Maryland Highway, Swanton, Md. 21561</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Tichnell Cemetery</b>		Date <b>09/30/00</b>		20c. Location - City or Town, State <b>Swanton, Maryland</b>			
	21. Signature of Funeral Service Licensee <b>J. Wayne Bal</b>				22. Name and Address of Facility <b>Boal Funeral Home 111 Church St., Westernport, Maryland 21562</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>48 Hours</b>									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pneumonia</b> <b>CONGESTIVE HEART FAILURE</b>									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier <b>S. Changin</b>				29c. License number <b>D256 38</b>			29d. Date signed (Month, Day, Year) <b>September 28, 2000</b>		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SARAH CHANE 10701 New Henge Creek S.W. Suite 3 Frostburg Maryland 21532</b>									
	31. Date filed (Month, Day, Year) <b>SEP 29 2000</b>		32. Registrar's Signature <b>B. [Signature]</b>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 32648

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Harry Terry, Jr.</b>				2. Date of Death Month <b>August</b> Day <b>28</b> Year <b>2000</b>				3. Time of Death <b>10:02 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>40341 Bay Drive</b>				4b. City, Town, or Location of Death <b>Mechanicsville</b>				4c. County of Death <b>St. Mary's</b>	
Funeral Director	5. Social Security Number <b>229-32-0632</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>70</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar. 24, 1930</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>Mechanicsville</b>				10d. Inside City Limits <b>1 Yes 2 No</b>		
10e. Street and Number <b>40341 Bay Drive</b>				10f. Zip Code <b>20659</b>				10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>			12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: White</b>	
15. Decedent's Education (Specify only highest grade completed) <b>Unknown</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Unknown</b>				16b. Kind of Business/Industry <b>Unknown</b>		
17. Father's Name (First, Middle, Last) <b>Harry Terry, Sr.</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Thelma McBride</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Sharon A. Hutchens/Daughter</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>135 Woods Landing Trail, Oldsmar, Florida 34677</b>				
20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crematory Brinsfield-Echols</b>		Date <b>9-6-00</b>		20c. Location - City or Town, State <b>Charlotte Hall, MD</b>		
21. Signature of Funeral Service Licensee <b>Edward N. Brinsfield, Jr.</b>				22. Name and Address of Facility <b>Brinsfield Funeral Home, P.A.</b>		20650 <b>22955 Hollywood Road, Leonardtown, Maryland</b>				
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Probable Myocardial Infarction</b>										
23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>										
24a. Was an autopsy performed? <b>1 Yes 2 No</b>										
24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>										
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>										
26. Place of Death (Check only one) <b>1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)</b>										
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>										
29b. Signature and Title of certifier <b>William Boyd II</b>										
29c. License number <b>114285</b>				29d. Date signed (Month, Day, Year) <b>9-1-00</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William Boyd II, 25365 Point Lookout Road, Leonardtown, Maryland 20650</b>										
31. Date filed (Month, Day, Year) <b>SEP 08 2000</b>										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner






Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32649

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alice Joanne Umbel</b>						2. Date of Death Month Day Year <b>September 20, 2000</b>		3. Time of Death <b>7:40 p.m.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Garrett County Memorial Hospital</b>						4b. City, Town, or Location of Death <b>Oakland</b>		4c. County of Death <b>Garrett</b>		
Funeral Director	5. Social Security Number <b>215-44-9010</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>53</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec 9, 1946</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>Garrett</b>		10c. City, Town or Location <b>Oakland</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number <b>4687 Oakland-Sang Run Road</b>				10f. Zip Code <b>21550</b>		10g. Citizen of What Country? <b>USA</b>					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 th</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>				
17. Father's Name (First, Middle, Last) <b>Dallas A. Durst</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Beulah E. Hare</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Richard Umbel/husband</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4687 Oakland-Sang Run Rd., Oakland, MD 21550</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Steele Cemetery, Sept 23, 2000</b>			20c. Location - City or Town, State <b>Friendsville, MD</b>					
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD 21536</b>					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Cerebrovascular Accident</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <b>48 hr.</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alcoholic Cirrhosis</b> <b>Chronic Obstructive Lung Disease</b>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier 			29c. License number <b>D27205</b>		29d. Date signed (Month, Day, Year) <b>9/21/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KARL E. SCHWALM 311 N. 4TH ST. OAKLAND, MD</b>											
31. Date filed (Month, Day, Year) <b>SEP 25 2000</b>			32. Registrar's Signature 								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32650

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph J. Vlach

2. Date of Death  
Month Day Year  
September 27, 2000

3. Time of Death  
1:30 AM

4a. Facility Name (If not institution, give street and number)

Sinai of BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

080-14-3315

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 13, 1922

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2805 Erdman Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th Grade

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print) (Personal)

Rev. Richard J. Bozzelli Rep)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

110 W. Lafayette Avenue, Baltimore, Md. 21217

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

9/28/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Schimunek Funeral Home Inc.

3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CAD, History of MI, COPD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

September 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARYAM KASHI, D.O.

SINAI HOSPITAL OF BALTIMORE

31. Date filed (Month, Day, Year)

SEP 29 2000

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 32651

Reg. No.

Baltimore, Maryland 21215-0020  
 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
 Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>BARBARA LOGAN WOLF</b>				2. Date of Death Month <b>Sept.</b> Day <b>23</b> Year <b>2000</b>		3. Time of Death <b>5:45 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Holly Hill Manor Nursing Home</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>212-22-2654</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>4/14/1927</b>	
9. Birthplace (State or Foreign Country) <b>New York</b>							
Usual Residence of Decedent							
10a. State <b>MD.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>8314 Nunley Drive Apt. F</b>				10f. Zip Code <b>21234</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Caucasian</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>-</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Home</b>	
17. Father's Name (First, Middle, Last) <b>Hugh Logan</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lettie Linton</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Michael L. Desaulniers/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2319 Northcliff Drive Jarrettsville, Md. 21084</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Carroll Cremation</b>		Date <b>9/25</b>		20c. Location - City or Town, State <b>2000 Hampstead, Maryland</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>E.G. Kurtz &amp; Son Funeral Home, P.A. Jarrettsville, Maryland</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Alzheimer's Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>						Approximate Interval Between Onset and Death <b>Years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D-17041</b>		29d. Date signed (Month, Day, Year) <b>25 SEPTEMBER 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mark I. Leaver MD 1205 York Road St. 38 Lutherville MD 21093</b>							
31. Date filed (Month, Day, Year) <b>SEP 28 2000</b>		32. Registrar's Signature 					

2:25 PM, 10/1/77  
New York  
10/1/77

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32652

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GARET ELLIS WINANTS JR.

2. Date of Death

Month Day Year  
Sept. 23, 2000

3. Time of Death

?unk.

4a. Facility Name (If not institution, give street and number)

2637 Shepperd Road

4b. City, Town, or Location of Death

Monkton

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

216-28-0822

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
10/29/1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Monkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2637 Shepperd Road

10f. Zip Code

21111

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Co owner

16b. Kind of Business/Industry

Photography

17. Father's Name (First, Middle, Last)

Garet Ellis Winants Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Frances Leigh Bonsal

19a. Informant's Name/Relationship (Type, Print)

Peter Winants /Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20117  
2276 Foxcroft Road Middleburg, Virginia

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation

Date

9/25  
2000

20c. Location - City or Town, State

Hampstead, Maryland

21. Signature of Funeral Service Licensee

M. Blackden Kurtz

22. Name and Address of Facility

E.G. Kurtz & Son Funeral Home, P.A.  
Jarrettsville, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line

Immediate Cause (Final disease or condition resulting in death)

a.

Acute myocardial infarction

hours

Due to (or as a consequence of):

b.

hypercholesterolemia

years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral palsy

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mark S. Kaplan MD

29c. License number

P19155

29d. Date signed (Month, Day, Year)

9/25/00

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

MARK S. KAPLAN MD, 16921 YORK RD MONKTON MD 21111

31. Date filed (Month, Day, Year)

SEP 26 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32653

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Harry B. Walters</b>				2. Date of Death Month <b>Oct.</b> Day <b>4,</b> Year <b>2000</b>		3. Time of Death <b>1:03PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>119 Carolyn Avenue</b>				4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>220-28-2086</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>11/20/1931</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10e. State <b>MD</b>		10b. County <b>Somerset</b>		10c. City, Town or Location <b>Deal Island</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>Edelyn Webster Road</b>		10f. Zip Code <b>21821</b>	
	10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>none</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>		16b. Kind of Business/Industry <b>Seafood</b>	
	17. Father's Name (First, Middle, Last) <b>Willie Walters</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Addie Bedsworth</b>		19a. Informant's Name/Relationship (Type, Print) <b>William Walters/Brother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>119 Carolyn Ave., Salisbury, Md. 21804</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Peters U.M. Cemetery</b>		Date <b>10/7/00</b>		20c. Location - City or Town, State <b>Oriole, Md.</b>	
	21. Signature of Funeral Service Licensee  <b>MO0295</b>		22. Name and Address of Facility <b>Hinman Funeral Home</b> <b>11673 Somerset Ave., Princess Anne, Md. 21853</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. <b>Coronary Artery Disease</b> Due to (or as a consequence of): b. <b>Atherosclerosis</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>Years</b>			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
	28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D 36783</b>	
29d. Date signed (Month, Day, Year) <b>10/05/00</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jeffery L. Thornton, MD, PRINC, SALISBURY, MD - 21804</b>		31. Date filed (Month, Day, Year) <b>OCT 06 2000</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32654

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DELLA F. WARD

2. Date of Death

Month September Day 28, Year 2000

3. Time of Death

6:02 PM

4a. Facility Name (If not institution, give street and number)

McCready Memorial Hospital

4b. City, Town, or Location of Death

Crisfield

4c. County of Death

Somerset

Funeral  
Director

5. Social Security Number

214-28-2165

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 23, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Somerset10c. City, Town or Location  
Crisfield

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

28 Anchor Drive

10f. Zip Code

21817

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Tent Mfg.

17. Father's Name (First, Middle, Last)

Albert Larrimore

18. Mother's Name (First, Middle, Maiden Surname)

Vina Hignutt

19a. Informant's Name/Relationship (Type, Print)

Christina Ward (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

28 Anchor Drive - Crisfield, MD 21817

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Sunnyridge Memorial Park

Date

10/1/00

20c. Location - City or Town, State

Crisfield, MD

21. Signature of Funeral Service Licensee

Robert H. Bradshaw, Jr.

22. Name and Address of Facility

Bradshaw & Sons Funeral Home  
306 W. Main St. - Crisfield, MD 2181723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Renal Failure

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Electrolytes Imbalance; Coronary  
Artery Disease; @ Frontal Infarction,  
COPD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 0054422

29d. Date signed (Month, Day, Year)

October 1, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sarad Baral, M.D. - 1604 Market Street - Pocomoke City, MD 21851

31. Date filed (Month, Day, Year)

OCT 03 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32655

AMEND ITEM: 4C PER PER PHY G788 10-19-00 WR

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Joel R. Wold				2. Date of Death Month Day Year SEPTEMBER 09, 2000				3. Time of Death 00:41 AM		
	4a. Facility Name (If not institution, give street and number) SHOCK TRAUMA UNIT				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death <del>Frederick</del>		
Funeral Director	5. Social Security Number 220-74-9851		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 42 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 3, 1957		9. Birthplace (State or Foreign Country) Montana		
	Usual Residence of Decedent				10a. State Maryland		10b. County Frederick		10c. City, Town or Location Mt. Airy		
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 6603 Charles Drive				10f. Zip Code 21771		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Physicians Assistant				16b. Kind of Business/Industry Health Care			
17. Father's Name (First, Middle, Last) Gary Wold				18. Mother's Name (First, Middle, Maiden Surname) Ednamae Southworth							
19a. Informant's Name/Relationship (Type, Print) Linda K. Wold/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6603 Charles Drive, Mt. Airy, Maryland 21771							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Prospect Cemetery				20c. Location - City or Town, State Mt. Airy, Maryland		20d. Date 9/12/2000	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				a. Multiple Injuries Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.				Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
				24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) 9-8-00		28b. Time of Injury 18 00 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred pedestrian struck by auto	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Roadway				28b. Location (Street and Number or Rural Route Number, City or Town, State) 13107 Old Annapolis Rd							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number OCME		29d. Date signed (Month, Day, Year) SEPTEMBER 09, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David R. Fowler				111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) SEP 13 2000				32. Registrar's Signature 							

ORIGINAL

Page 100

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 32656

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Willey

2. Date of Death

Month 9 Day 28 Year 00

3. Time of Death

9:50pm.

4a. Facility Name (If not institution, give street and number)

VA Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

220-28-2146

6. Sex

XXM 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 27, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Taylors Island

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4438 Hooper Neck Road

10f. Zip Code

21669

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Elmer Willey

18. Mother's Name (First, Middle, Maiden Surname)

Fannie Horseman

19a. Informant's Name/Relationship (Type, Print)

Thomas L. Willey Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 14 Taylors Island, Maryland 21669

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veterans Cemetery

Date

10-3-00

20c. Location - City or Town, State

Hurlock, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Thomas Funeral Home, P.A.  
700 Locust Street Cambridge, Maryland 21613

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]* Resident Physician

29c. License number

P12381

29d. Date signed (Month, Day, Year)

9/28/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alex Chudnovsky M.D. 10 North Greene Street Baltimore, MD 21201

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 03 2000

32. Registrar's Signature

*[Signature]* B. Sparks

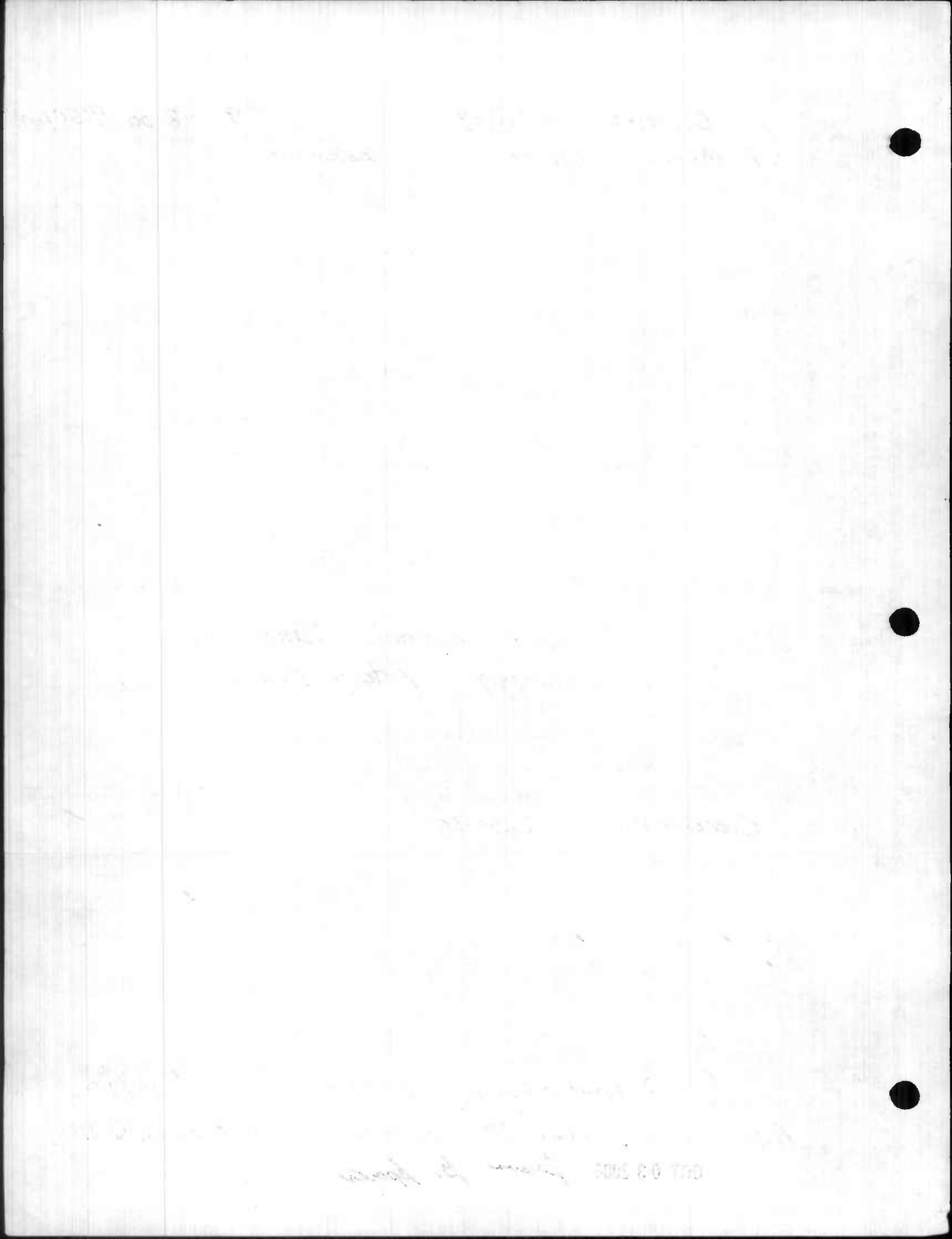
To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020  
permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Oct 9 3 30 PM

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32657

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARILYN BACON WILDERSON				2. Date of Death Month Day Year SEPT. 23 2000		3. Time of Death 11:15 AM	
	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 481-56-6215	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEPT. 21, 1945		9. Birthplace (State or Foreign Country) SOUTH DAKOTA
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MD	10b. County QUEEN ANNE'S		10c. City, Town or Location STEVENSVILLE			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 419 LOVE POINT ROAD				10f. Zip Code 21666		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WRITER/ EDITOR			16b. Kind of Business/Industry LITERARY		
	17. Father's Name (First, Middle, Last) OMAR BACON				18. Mother's Name (First, Middle, Maiden Surname) MILDRED VOGES			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) PAUL W. WILDERSON, III/ HUSBAND				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 LOVE POINT ROAD, STEVENSVILLE, MD 21666			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CHESAPEAKE CREMATION CTR		Date 9-27-2000		20c. Location - City or Town, State STEVENSVILLE, MD	
	21. Signature of Funeral Service Licensee <i>Chad M. H. [Signature]</i>				22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>intraabdominal adenocarcinoma</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death 8 years							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>F. Selouid</i>		29c. License number 019838		29d. Date signed (Month, Day, Year) 9/24/2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STUART E. SELOUID 900 Bestgate Rd. Annapolis, Md.								
State Registrar	31. Date filed (Month, Day, Year) SEP 27 2000		32. Registrar's Signature <i>Denise B. Sparks</i>					

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 32658

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lisa Michelle Wade				2. Date of Death Month Day Year September 20, 2000		3. Time of Death 8:23 P.M.		
	4a. Facility Name (If not institution, give street and number) 18535 Maryland Highway				4b. City, Town, or Location of Death Bloomington		4c. County of Death Garrett		
Funeral Director	5. Social Security Number 216-08-8559		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 15 Yrs.		8. Date of Birth (Month, Day, Year) Apr. 22, 1985		
	10a. State MD.		10b. County Garrett		10c. City, Town or Location Swanton		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 18461 Maryland Highway				10f. Zip Code 21561		10g. Citizen of What Country? United States			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4or 5+) student				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) student		16b. Kind of Business/Industry school			
17. Father's Name (First, Middle, Last) Daniel Wade				18. Mother's Name (First, Middle, Maiden Surname) Lois Broadwater					
19a. Informant's Name/Relationship (Type, Print) Lois Wade/ mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18461 Maryland Highway, Swanton, Md. 21561					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bloomington Cemetery		20c. Location - City or Town, State 9/24/00 Bloomington, Maryland					
21. Signature of Funeral Service Licensee F. W. [Signature]				22. Name and Address of Facility Boal Funeral Home 111 Church St., Westernport, Md. 21562					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Multiple Injuries Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.				Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
				24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
				24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene							
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) 9/24/00		28b. Time of Injury 1945 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Pedestrian struck by vehicle	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) September 22, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Talon Locke, MD 111 Penn Street, Baltimore, Maryland 21201									
31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature [Signature]							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 32659

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Iva Mae Woods

2. Date of Death  
Month Day Year

SEPTEMBER 24 2000 07:10 AM

3. Time of Death

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary's

Funeral  
Director

5. Social Security Number

578-12-1182

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 24, 1911

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Colton Point

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

37964 Enfield Lane

10f. Zip Code

20626

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Medical Aide

16b. Kind of Business/Industry

US Government

17. Father's Name (First, Middle, Last)

Frank W. McGuire

18. Mother's Name (First, Middle, Maiden Surname)

Eva Frances Vallandingham

19a. Informant's Name/Relationship (Type, Print)

James A. Woods / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 101, Clements, Maryland 20624

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Queen of Peace Cemetery

Date

9-29-00

20c. Location - City or Town, State

Helen, Maryland

21. Signature of Funeral Service Licensee

Edward N. Brinsfield, Jr. M00052

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.

22955 Hollywood Road, Leonardtown, MD 20650-0279

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Bilateral Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 wk

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cardiomyopathy + Congestive heart failure  
Aortic stenosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D19917

29d. Date signed (Month, Day, Year)

9/25/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES C. BOYD M.D. P.O. BOX 730 23415 THREE NOTCH RD. CALIFORNIA, MD. 20619

31. Date filed (Month, Day, Year)

SEP 27 2000

32. Registrar's Signature

B. Spence

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

IVA MCGUIRE WOODS  
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32660

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Emma Frances Wolfe				2. Date of Death Month Day Year August 31, 2000				3. Time of Death 9:35 AM		
	4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center				4b. City, Town, or Location of Death Leonardtown				4c. County of Death St. Mary's		
Funeral Director	5. Social Security Number 217-80-9172		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 85 Yrs.		8. Date of Birth (Month, Day, Year) August 31, 1915		9. Birthplace (State or Foreign Country) Virginia		
	Usual Residence of Decedent										
10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Chaptico				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 36175 Notley Hall Road				10f. Zip Code 20621				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Luther Cager Howerton					18. Mother's Name (First, Middle, Maiden Surname) Cora Lee Reeves						
19a. Informant's Name/Relationship (Type, Print) Luther H. Wolfe (son)					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36206 Old Chaptico Wharf Road, Chaptico, Maryland 20621						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) St. Paul Methodist Cemetery		Date 9/2/2000		20c. Location - City or Town, State Leonardtown, Maryland				
21. Signature of Funeral Service Licensee <i>Michael Gardiner</i>					22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650						
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Congestive Heart failure</u> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____										Approximate Interval Between Onset and Death <u>Ten years</u>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <u>SC Gabry</u> M.D.					29c. License number D54346		29d. Date signed (Month, Day, Year) 9/1/00				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chandra Sajja, MD Hollywood, Maryland 20636											
31. Date filed (Month, Day, Year) SEP 01 2000		32. Registrar's Signature <i>B. Sparks</i>									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Handwritten signature

90125 1 0 632



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32661

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARTHA H. YEWELL						2. Date of Death Month Day Year SEPT. 22 2000		3. Time of Death 3:12 PM	
	4a. Facility Name (If not institution, give street and number) MINK HILL HOME						4b. City, Town, or Location of Death GRASONVILLE		4c. County of Death QUEEN ANNE'S	
Funeral Director	5. Social Security Number 218-20-4745		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 5, 1907		9. Birthplace (State or Foreign Country) GERMANY	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County QUEEN ANNE'S		10c. City, Town or Location GRASONVILLE				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 4008 MAIN ST.				10f. Zip Code 21638		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) -0-				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME		
	17. Father's Name (First, Middle, Last) HEINRICK HOLDERRIETH						18. Mother's Name (First, Middle, Maiden Surname) CHRISTINA BERHARDT			
	19a. Informant's Name/Relationship (Type, Print) MARION W. YEWELL/ SON						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7434 CEMETERY AVENUE, PITTSVILLE, MD 21850			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) CHESTERFIELD CEMETERY		20c. Location - City or Town, State 9-26-2000 CENTREVILLE, MD			
	21. Signature of Funeral Service Licensee 						22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Colon cancer Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
23c. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
23d. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify Assisted Living)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined										
28a. Date of injury (Month, Day, Year) 28b. Time of injury M 28c. Injury at work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 										
29c. License number 032036										
29d. Date signed (Month, Day, Year) 9/25/2000										
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Gay J Sprone 2108 P. Bonita Drive Chester, MD 21619										
31. Date filed (Month, Day, Year) SEP 26 2000										
32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32662

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) George Francis Young				2. Date of Death Month: September Day: 20, Year: 2000				3. Time of Death 11:55 AM	
	4a. Facility Name (If not Institution, give street and number) 22001 Valley Drive Estates Apt. 211				4b. City, Town, or Location of Death Lexington Park				4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 220-16-7880		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) April 25, 1912		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10c. City, Town or Location Lexington Park		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Funeral Director	10e. State Maryland		10b. County St. Mary's		10f. Zip Code 20653				10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5th		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Farmer				16b. Kind of Business/Industry Farm	
	17. Father's Name (First, Middle, Last) Philip Young				18. Mother's Name (First, Middle, Maiden Surname) Mary Neil					
	19a. Informant's Name/Relationship (Type, Print) Catherine Young (Spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22001 Valley Drive Estates Apt. 211 Lexington Park, MD 20653					
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Our Lady's Cemetery		Date 9/25/00		20c. Location - City or Town, State Leonardtown, Maryland			
	21. Signature of Funeral Service Licensee <i>Michael Kevin Gardiner</i>				22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Cardiopulmonary Arrest</i> Due to (or as a consequence of): b. <i>Cardiomyopathy</i> Due to (or as a consequence of): c. <i>Hypertensive Heart Disease</i> Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Aortic valve insufficiency</i> <i>Dementia</i> <i>Gastroesophageal reflux disease</i> <i>Cancer of prostate and cervix</i>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>				29c. License number D 51738		29d. Date signed (Month, Day, Year) 9/21/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kae T. Aung, MD Hollywood, Maryland 20636										
31. Date filed (Month, Day, Year) SEP 25 2000		32. Registrar's Signature <i>[Signature]</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



00 32663

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>Louis Edwin Zupancic</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Sept. 28, 2000</b>		3. TIME OF DEATH <b>5:00 P.M. M</b>	
4. SOCIAL SECURITY NUMBER <b>214-36-9035</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>61</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 28, 1939</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>210 Hiob Lane</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Aberdeen</b>	
9c. COUNTY OF DEATH <b>Harford</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Harford</b>	
10c. CITY, TOWN OR LOCATION <b>Aberdeen</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>210 Hiob Lane</b>	
10f. ZIP CODE <b>21001</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES <b>1959-1963</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Self Employed</b>				17. KIND OF BUSINESS/INDUSTRY <b>Welding</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Louis Frederick Zupancic</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Bell Piper</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Beverly E. Zupancic (Wife)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>210 Hiob Lane Aberdeen, Maryland 21001</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>P.O.S. of A. Cemetery 10/2</b>			
20c. LOCATION — City or Town, State <b>Hooversville, PA</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kenneth B. Bays</i>			
22. NAME AND ADDRESS OF FACILITY <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Atherosclerotic coronary artery disease</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>28b. TIME OF INJURY M</b> 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED <b>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</b>			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles Eck</i> MD 29c. LICENSE NUMBER <b>D31712</b> 29d. DATE SIGNED (Month, Day, Year) <b>9/29/00</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CHARLES ECK MD 2901 BEL AIR AVE ABERDEEN, MD 21001</b>				31. DATE FILED (Month, Day, Year) <b>OCT 1 - 2000</b> 32. REGISTRAR'S SIGNATURE <i>P. Sparks</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32664

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ISABEL Allen</b>				2. Date of Death Month <b>10</b> Day <b>14</b> Year <b>00</b>		3. Time of Death <b>12:13 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>2505 Painter Court</b>				4b. City, Town, or Location of Death <b>ANNAPOLIS</b>		4c. County of Death <b>ANNE ARUNDEL</b>		
Funeral Director	5. Social Security Number <b>216-44-3645</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth Month <b>2</b> Day <b>19</b> Year <b>1912</b>		
	9. Birthplace (State or Foreign Country) <b>Iowa</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>		
Usual Residence of Decedent		10d. Inside City Limits <b>1</b> Yes <b>2</b> No		10e. Street and Number <b>2505 Painter Court</b>		10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>College (14 or 5+)</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Analyst</b>		16b. Kind of Business/Industry <b>Federal Government</b>		17. Father's Name (First, Middle, Last) <b>Clement C. Liddy</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Kiburz</b>		19a. Informant's Name/Relationship (Type, Print) <b>Norval Allen/husband</b>	
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2505 Painter Court Annapolis, MD 21401</b>		20a. Method of Disposition <b>1</b> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>		20d. Date <b>10/16/00</b>	
21. Signature of Funeral Service Licensee <b>Dawn F. McDonald</b>		22. Name and Address of Facility <b>Cremation Society of Maryland, Inc.</b> <b>299 Frederick Road Baltimore, MD 21228</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>METASTATIC BREAST CANCER</b>		Approximate Interval Between Onset and Death <b>3 YRS.</b>		23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No <b>3</b> Probably <b>4</b> Unknown	
23c. Immediate Cause (Final disease or condition resulting in death)		23d. Due to (or as a consequence of):		23e. Due to (or as a consequence of):		23f. Due to (or as a consequence of):		23g. Due to (or as a consequence of):	
23h. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23i. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23j. Was an autopsy performed? <b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No		23k. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No		23l. Was a coroner's inquest held? <b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> Other (Specify)		27. Manner of Death <b>1</b> <input checked="" type="checkbox"/> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending investigation <b>6</b> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		28g. Date signed (Month, Day, Year) <b>10/14/00</b>	
29a. Certifier (Check only one) <b>1</b> <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Mary L. Michaels MD</b>		29c. License number <b>D31082</b>		29d. Date signed (Month, Day, Year) <b>10/14/00</b>		29e. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY L. MICHELS MD 706 GIDDINGS AVE #2B ANNAPOLIS MD 21401</b>	
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature <b>B. Sparks</b>		33. State Registrar <b>State Registrar</b>		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	

ORIGINAL

43636


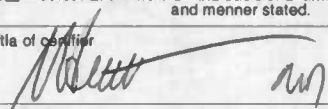
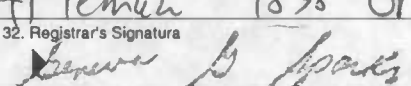
0

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32665

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT LEE ABRAMS</b>				2. Date of Death Month Day Year <b>OCTOBER 12, 2000</b>		3. Time of Death <b>5:25 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>BRIGHTWOOD MERIDIAN NURSING CENTER</b>				4b. City, Town, or Location of Death <b>LUTHERVILLE</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>217-48-5581</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>50</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEP. 22, 1950</b>		
	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)				16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ADMINISTRATOR</b>				16b. Kind of Business/Industry <b>TOMSON-PROMETRIC</b>	
17. Father's Name (First, Middle, Last) <b>MELVIN J. ABRAMS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LUCILLE GOLDSTEIN</b>					
19a. Informant's Name/Relationship (Type, Print) <b>SANFORD ABRAMS / BROTHER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>25 COTSWOLD COURT - OWINGS MILLS, MD 21117</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARLINGTON CHIZUK AMUNO</b>				20c. Location - City or Town, State <b>10/16/00 BALTIMORE, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>					
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Urinary bladder Carcinoma with metastasis Unknown</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Renal failure Anemia</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal failure Anemia</b>				23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>					
24a. Was an autopsy performed? <b>1 Yes 2 No</b>				24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>D27565</b>	
29d. Data signed (Month, Day, Year) <b>10/12/00</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Allen Hettlemann 1838 Greene Tree Rd #300</b>					
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>				32. Registrar's Signature 					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item#16a,b,19a,b perFHG788 10/18/2000 EW

State of Maryland / Department of Health and Mental Hygiene

Amended Item#7 perFHG788 10/17/2000 EW

## Certificate of Death

Reg. No.

00 32666

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>LILLIAN L. BOLDEN</u>				2. Date of Death Month <u>OCT.</u> Day <u>1</u> Year <u>2000</u>		3. Time of Death <u>6:55 PM</u>				
	4a. Facility Name (If not institution, give street and number) <u>4511 ROBOSON RD NSG. CTR.</u>				4b. City, Town, or Location of Death <u>RANDALLSTOWN MD</u>		4c. County of Death <u>BALTIMORE</u>				
Funeral Director	5. Social Security Number <u>218-36-828</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>83</u> 82 Yrs.		8. Date of Birth (Month, Day, Year) <u>12-18-17</u>				
	9. Birthplace (State or Foreign Country) <u>MD</u>		10a. State <u>MD</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Randallstown</u>				
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <u>4511 Robosson Road</u>		10f. Zip Code <u>21133</u>		10g. Citizen of What Country? <u>USA</u>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>black</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>+5</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>unk</u> <u>Teacher</u>				16b. Kind of Business/Industry <u>unk</u> <u>Balto City School System</u>			
17. Father's Name (First, Middle, Last) <u>George Lottier</u>						18. Mother's Name (First, Middle, Maiden Surname) <u>Lilian Armstrong</u>					
19a. Informant's Name/Relationship (Type, Print) <u>unk</u> <u>Patrice Williams - Daughter</u>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>unk</u> <u>9451 Fitzharding Lane Owings Mills, Md</u>					
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>State Anatomy Board</u>				Date <u>655 W. Baltimore Street</u>		20c. Location - City or Town, State <u>Baltimore, MD 21201</u>	
21. Signature of Funeral Service Licensee <u>Ronald S. Wade, Director</u>						22. Name and Address of Facility <u>State Anatomy Board</u>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>a. Pneumonia</u> Due to (or as a consequence of):  <u>b. Chronic Aspiration</u> Due to (or as a consequence of):  <u>c.</u> Due to (or as a consequence of):  <u>d.</u>										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Peripheral Vascular Disease</u>										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <u>Allen J. Cheneus MD</u>						29c. License number <u>029085</u>			29d. Date signed (Month, Day, Year) <u>October 2 2000</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Allen J. Cheneus MD 5210 Old Court RD 21133</u>											
31. Date filed (Month, Day, Year) <u>OCT 17 2000</u>				32. Registrar's Signature <u>[Signature]</u>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32667

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DARNELL LAMONT BURRELL

2. Date of Death  
Month Day Year  
OCTOBER 14, 20003. Time of Death  
6:30am

4a. Facility Name (If not institution, give street and number)

1806 N. CAREY STREET

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

217-13-8631

6. Sex  
1 ☒ M 2 ☐ F7. Age (In yrs. last birthday)  
31 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
JULY 7, 19699. Birthplace (State or Foreign  
Country)  
MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1806 N. CAREY STREET

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: AFRICAN  
AMERICAN15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
11thCollege (1-4or 5+)  
NA16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

CUSTODIAN

16b. Kind of Business/Industry

PATRIOT, INC.

17. Father's Name (First, Middle, Last)

TYRONE LAMONT BURRELL

18. Mother's Name (First, Middle, Maiden Surname)

JOYCE DARNELL WYSE

19a. Informant's Name/Relationship (Type, Print)

TYRONE L. BURRELL (FATHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1806 N. CAREY STREET BALTIMORE, MD 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

MOUNT ZION CEMETERY

Date

10/21/00

20c. Location - City or Town, State

LANSDOWNE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WYLIE FUNERAL HOME PA

638 N. GILMOR STREET BALTIMORE, MD 21217

23a. Print. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Burkitts Lymphoma  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

2 MONTHS

b. AIDS  
Due to (or as a consequence of):

6 MONTHS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Darnell Burrell MD

29c. License number

D06933

29d. Date signed (Month, Day, Year)

10/16/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN B MacGIBSON MD 300 ARMORY PLACE SUITE 3G BALTIMORE MD 21201

31. Date filed (Month, Day, Year)

OCT 17 2000

32. Registrar's Signature

Benita S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitDarnell Burrell 10-14-00 @ 3:30am  
Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32668

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EDMUND

(NMN)

BIRK

2. Date of Death

Month  
OCTOBERDay  
13Year  
2000

3. Time of Death

12:20 AM

4a. Facility Name (If not institution, give street and number)

GENESIS ELDER CARE

4b. City, Town, or Location of Death

SEVERNA PARK

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

212-10-5951

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
JUNE 25, 1913

9. Birthplace (State or Foreign Country)

WI

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7302 GREEN ACRES DRIVE

10f. Zip Code

21060

10g. Citizen of What Country?

U. S. A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

CARPENTER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

ALEXANDER

BIRK

18. Mother's Name (First, Middle, Maiden Surname)

MARY

HALLIKAS

19a. Informant's Name/Relationship (Type, Print)

MRS. DAWN HANSON (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7311 MARLEY NECK BLVD., GLEN BURNIE, MD. 21060

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GLEN HAVEN MEMORIAL PARK

Date

10/17/2000

20c. Location - City or Town, State

GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SINGLETON FUNERAL HOME, P.A.,

1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Wound Infection - Left Hip

Due to (or as a consequence of):

b. Severe Peripheral Vascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 year

&gt; 2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension  
Atrial Fibrillation  
Vascular Dementia - severe

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John F. Loomer, M.D.

29c. License number

D52728

29d. Date signed (Month, Day, Year)

October 13, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John F. Loomer, M.D. 479 Jumpers Hole Rd. #304 Severna Park, MD 21146

31. Date filed (Month, Day, Year)

OCT 17 2000

32. Registrar's Signature

Beverly S. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit record.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


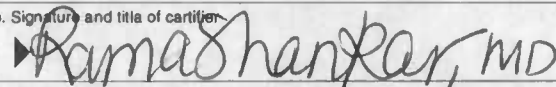
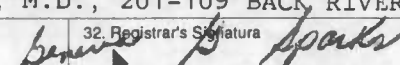
State of Maryland / Department of Health and Mental Hygiene

00 32669

AMEND#26 PER MD. G788 10-17-2000 JAB

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHESTER FRANK BORUTA</b>		2. Date of Death Month Day Year <b>OCTOBER 12, 2000</b>		3. Time of Death <b>2:20 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>STELLA MARIS NURSING HOME</b>		4b. City, Town, or Location of Death <b>TIMONIUM</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>376-26-9995</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>AUG 4, 1915</b>	9. Birthplace (State or Foreign Country) <b>MICHIGAN</b>
	Usual Residence of Decedent 10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>ANNAPOLIS</b>
10e. Street and Number <b>835 COACHWAY</b>		10f. Zip Code <b>21401</b>		10g. Citizen of What Country? <b>U S A</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-1965</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MILITARY LINGUIST</b>	
16b. Kind of Business/Industry <b>SOCIAL SECURITY</b>		17. Father's Name (First, Middle, Last) <b>FRANK BORUTA</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ANNA BOLEK</b>	
19a. Informant's Name/Relationship (Type, Print) <b>MS. MADELINE AGLUBAT (DAUGHTER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1010 CHESTNUT RIDGE DRIVE LUTHERVILLE MD 21093</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GLEN HAVEN MEMORIAL PARK</b>		20c. Location - City or Town, State <b>GLEN BURNIE, MD.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>END STAGE SENILE DEMENTIA</b> Due to (or as a consequence of): b. <b>PEPTIC ULCER DISEASE</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D0048046</b>	
29d. Date signed (Month, Day, Year) <b>10-12-00</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. RAMA SHANKAR, M.D., 201-109 BACK RIVER NECK ROAD, BALTIMORE, MARYLAND 21221</b>			
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature 			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32670

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charlotte Borisevic</b>				2. Date of Death Month Day Year <b>October 13 2000</b>		3. Time of Death <b>2:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Union Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>--</b>	
Funeral Director	5. Social Security Number <b>213-34-2749</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b>		8. Date of Birth (Month, Day, Year) <b>January 2, 1924</b>	
	9. Birthplace (State or Foreign Country) <b>Germany</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>929 Prestwood Road</b>		10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bookkeeper</b>		16b. Kind of Business/Industry <b>Accounting</b>			
	17. Father's Name (First, Middle, Last) <b>Julius Foster</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Stein</b>		19a. Informant's Name/Relationship (Type, Print) <b>William Edward Borisevic-Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>542 Crossbridge Drive-Westminster, Maryland 21158</b>	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crestlawn Memorial Gardens</b>		20c. Location - City or Town, State <b>Marriottsville, Maryland</b>		20d. Date <b>October 17, 2000</b>	
	21. Signature of Funeral Service Licensee <b>Shanda L L Lemmer</b>		22. Name and Address of Facility <b>Witzke Funeral Home, Inc. 1630 Edmondson Avenue, Catonsville, Maryland 21228</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>Right Heart Failure</b> Due to (or as a consequence of): b. <b>Mitral Regurgitation</b> Due to (or as a consequence of): c. <b>Congestive Heart Failure</b> Due to (or as a consequence of): d. Approximate interval between Onset and Death <b>2 hours</b> <b>1 day</b> <b>1 day</b>			
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>October 13 2000</b>	
To Be Completed by Physician/Medical Examiner	28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>MD 31894</b>		29c. License number <b>MD 31894</b>	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) <b>October 13 2000</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Marie Margolis MD / Union Memorial Hospital</b>		31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature <b>Sparks</b>	



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32671

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carolyn LaVern Booker

2. Date of Death

Month Day Year

October 15, 2000

3. Time of Death

1:10AM

4a. Facility Name (If not institution, give street and number)

Charlestown Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

170-12-9736

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

January 14, 1916

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

709 Maiden Choice Lane

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Andrew Clark

18. Mother's Name (First, Middle, Maiden Surname)

Jenny Barton

19a. Informant's Name/Relationship (Type, Print)

Rick Jay- Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3821 Bonnybridge Place, Ellicott City, Maryland 21043

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Crestlawn Memorial Gardens

Date

October

18, 2000

20c. Location - City or Town, State

Marriottsville, Maryland

21045

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Home, Inc.

1630 Edmondson Avenue, Catonsville, Maryland 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Immediate Cause (Final

disease or condition

resulting in death)

a. Stroke

Due to (or as a consequence of):

Approximate

Interval Between

Onset and Death

2 weeks

Sequentially list conditions,

if any, leading to immediate

cause. Enter Underlying

Cause (Disease or injury

that initiated events

resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

vascular heart + disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D47009

29d. Date signed (Month, Day, Year)

October 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Phillip Stone, 711 Maiden Choice Lane, Baltimore, MD 21228

31. Date filed (Month, Day, Year)

OCT 17 2000

32. Registrar's Signature

State

Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

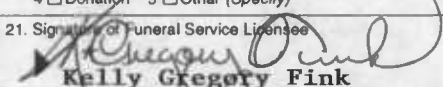
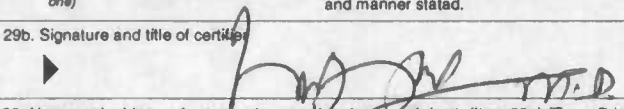
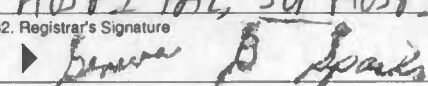


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State of Maryland / Department of Health and Mental Hygiene 00 32672

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Gladys M. Burkins</b>				2. Date of Death Month Day Year <b>OCTOBER 10 2000</b>		3. Time of Death <b>11:15 PM</b>		
	4a. Facility Name (If not Institution, give street and number) <b>NORTH ARUNDEL HOSPITAL</b>				4b. City, Town, or Location of Death <b>GLEN BURNIE</b>		4c. County of Death <b>ANNE ARUNDEL</b>		
Funeral Director	5. Social Security Number <b>198-05-4224</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>2/16/1911</b>		
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Glen Burnie</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>528 Oakwood Station Road</b>		10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>Johnson Hodge</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret A. Ferguson</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Norman E. Burkins - Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>528 Oakwood Station Road, Glen Buirnie, MD 21061</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Cemetery</b>		Date <b>10/13</b>		20c. Location - City or Town, State <b>Glen Burnie, MD</b>			
21. Signature of Funeral Service Licensee  <b>Kelly Gregory Fink</b>		22. Name and Address of Facility <b>FINK FUNERAL HOME, PA 426 Crain Hwy., SW, Glen Burnie, MD 21061</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>METASTATIC BREAST CANCER</b> Due to (or as a consequence of):  b. <b>PNEUMONIA</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D 51664</b>		29d. Date signed (Month, Day, Year) <b>OCTOBER 10 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>NORTH ARUNDEL HOSPITAL, 30 HOSPITAL DRIVE, GLENBURNIE MD 21061</b>									
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature 							

ORIGINAL




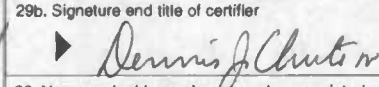
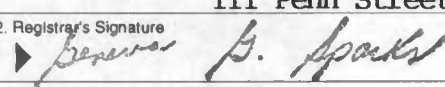


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State of Maryland / Department of Health and Mental Hygiene 00 32673

Certificate of Death

Reg. No.

<b>Physician /Medical Examiner</b>	1. Decedent's Name (First, Middle, Last) <b>LARRY BANKS</b>				2. Date of Death Month Day Year <b>OCTOBER 06 2000</b>		3. Time of Death <b>10:15 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>6120 LIVINGSTON ROAD</b>				4b. City, Town, or Location of Death <b>OXON HILL</b>		4c. County of Death <b>PRINCE GEORGE'S</b>		
<b>Funeral Director</b>	5. Social Security Number <b>111-38-5551</b>		6. Sex <b>XXM 20 F</b>		7. Age (In yrs. last birthday) <b>52 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>AUG 11 1948</b>		
	9. Birthplace (State or Foreign Country) <b>NEW YORK</b>		10a. State <b>MARYLAND</b>		10b. County <b>PRINCE GEORGE'S</b>		10c. City, Town or Location <b>OXON HILL</b>		
<b>To Be Completed by Funeral Director</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>2115 ALICE AVENUE APT 203</b>		10f. Zip Code <b>20749</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>68/77</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
<b>To Be Completed by Funeral Director</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CABLE TECHNICIAN</b>		16b. Kind of Business/Industry <b>VA DEPT OF TRANSPORTATION</b>			
		17. Father's Name (First, Middle, Last) <b>JOSHUA BANKS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>JOHNNY MAE SWINGER</b>		19a. Informant's Name/Relationship (Type, Print) <b>LAWRENCE D. BANKS/Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>308 Stuyvisant Ave., Brooklyn, New York 11233</b>	
<b>To Be Completed by Funeral Director</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CALVERTON NATIONAL</b>		20c. Location - City or Town, State <b>10/16/00 CALVERTON, NEW YORK</b>			
		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE</b>		23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  e. <b>Contact Gunshot Wound of Head</b> Due to (or as a consequence of):  f. Due to (or as a consequence of):  g. Due to (or as a consequence of):  h. Due to (or as a consequence of):		Approximate Interval Between Onset and Death	
<b>Physician /Medical Examiner</b>		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Medical Certification: To Be Completed by Physician/Medical Examiner</b>		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>					
		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Found 10-6-00</b>		28b. Time of Injury <b>1008 AM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<b>State Registrar</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>building</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Prince George's Co</b>		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>OCTOBER 7, 2000</b>			
<b>State Registrar</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dennis J Chute 111 Penn Street, Baltimore, Maryland 21201</b>							
		31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 32674

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alice E. Bigham</b>				2. Date of Death Month Day Year <b>Oct. 13, 2000</b>		3. Time of Death <b>6:20AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Stella Maris Hospice</b>				4b. City, Town, or Location of Death <b>Timonium</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>218-07-6516</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 17, 1917</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Timonium</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <b>412 Rockfleet Road Unit 101</b>		10f. Zip Code <b>21093</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>N/A</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>John A. Hughes</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Susan E. Ryan</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Mary Sue Bigham/ Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>412 Rockfleet Road Unit 101 Timonium, MD 21093</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial Gardens</b>		20c. Location - City or Town, State <b>Timonium, MD</b>	
	21. Signature of Funeral Director/Licensee  <b>Michael J. Flagle</b>				22. Name and Address of Facility <b>Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Cerebrovascular Accident</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accidental 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>Oct. 13, 2000</b>		28b. Time of Injury <b>M</b>		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred				
28e. Location (Street and Number or Rural Route Number, City or Town, State)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D43725</b>		29d. Date signed (Month, Day, Year) <b>10/13/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Tariq Mahmood, 2300 Dulaney Valley Road, Timonium, MD 21093</b>								
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>				32. Registrar's Signature 				

October 13, 2000 6:20 a.m.  
Baltimore, Maryland 21215-0020permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Alice Elizabeth Bigham  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

00 32675

LAMONT BEARD amend item 23a, pt II, 27, 28a, b, c, d, e, f per the 10/16/2000

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lamont T. Beard, Sr.</b>				2. Date of Death Month Day Year <b>OCT. 14, 2000</b>		3. Time of Death <b>1256 PM</b>									
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>									
Funeral Director	5. Social Security Number <b>218-64-0984</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>44</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>9-25-56</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>									
	Usual Residence of Decedent															
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
10e. Street and Number <b>5503 Lynview Ave</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>										
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Security Guard</b>		16b. Kind of Business/Industry <b>Housing Authority</b>										
17. Father's Name (First, Middle, Last) <b>Robert Beard</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mildred Griffin</b>												
19a. Informant's Name/Relationship (Type, Print) <b>Lamont T. Beard, Jr./son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3417 Clifmont Ave, Balt. MD 21213</b>												
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Voshell memorial</b>		Date <b>10/21/2000</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>										
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Harry P. Close Funeral Service, P.A. 709 Tessier St., Balt. MD 21201-1905</b>												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>MIXED DRUG INTOXICATION</b></td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. Due to (or as a consequence of):</td> </tr> <tr> <td>c. Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>d. Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>MIXED DRUG INTOXICATION</b>	Approximate Interval Between Onset and Death	Due to (or as a consequence of):	b. Due to (or as a consequence of):	c. Due to (or as a consequence of):	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d. Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)	a. <b>MIXED DRUG INTOXICATION</b>	Approximate Interval Between Onset and Death														
	Due to (or as a consequence of):															
	b. Due to (or as a consequence of):															
	c. Due to (or as a consequence of):															
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d. Due to (or as a consequence of):															
	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 5. Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>found: 10/14/00</b>		28b. Time of Injury <b>unknown</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
		28d. Describe how injury occurred <b>unknown</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>Central Booking, Baltimore City, Md.</b>												
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>OCT. 15, 2000</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201</b>																
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature 														

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32676

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mabel B. Baker				2. Date of Death Month Day Year October 13 2000				3. Time of Death 11:44 PM	
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center				4b. City, Town, or Location of Death Rosedale				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 212-09-6829		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) April 20, 1919		9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 320 S. Bouldin Street		10f. Zip Code 21224		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) George M. Backert Sr.		18. Mother's Name (First, Middle, Maiden Surname) Mabel Battee		19a. Informant's Name/Relationship (Type, Print) James Baker		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 320 S. Bouldin Street Baltimore, Maryland 21224		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oaklawn Cemetery		20c. Location - City or Town, State 10/17/00 Baltimore, Maryland		21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility Charles S. Zeiler & Sons, Inc. 6224 Eastern Avenue Baltimore, Maryland 21224		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute myocardial Infarction Due to (or as a consequence of): b. Ventricular Fibrillation Due to (or as a consequence of): c. Polymyalgia Rheumatica Due to (or as a consequence of): d. Lumbar Spinal Stenosis		Approximate Interval Between Onset and Death 1-2 hours 1-2 hours 10 years 2 years		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D14221		29d. Date signed (Month, Day, Year) October 14, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tarique Firozvi MD 223 Eastern BLVD Baltimore Maryland 21221		31. Date filed (Month, Day, Year) OCT 17 2000		32. Registrar's Signature 		33. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tarique Firozvi MD 223 Eastern BLVD Baltimore Maryland 21221		34. Date signed (Month, Day, Year) October 14, 2000		

ORIGINAL

1949

DHHM 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

00 32678

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Sylvester Cherry</b>		2. Date of Death Month <b>October</b> Day <b>15</b> Year <b>2000</b>		3. Time of Death <b>10:15 A.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>241-52-6220</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>01-21-36</b>		9. Birthplace (State or Foreign Country) <b>NC</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>2007 E. LaFayette Avenue</b>			10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>10th Grade</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cement Finisher</b>		16b. Kind of Business/Industry <b>Joseph Averza</b>	
17. Father's Name (First, Middle, Last) <b>Walter Cherry</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Vivian Gilliam</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Allene Cherry</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21213 2007 E. LaFayette Avenue Baltimore, Maryland</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		20c. Location - City or Town, State <b>10-21-2000 Lansdowne, MD</b>	
21. Signature of Funeral Service Licensee <b>Blades Wane</b>		22. Name and Address of Facility <b>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Arteriosclerotic Cardiovascular Disease</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <b>Inspection</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Joseph Pestaner, M.D.</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>October 15, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature <b>Benjamin B. Sparks</b>			







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State of Maryland / Department of Health and Mental Hygiene

00 32679

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Dorothy L. Coley</i>		2. Date of Death Month <i>10</i> Day <i>13</i> Year <i>2000</i>		3. Time of Death <i>10:54 PM</i>
	4e. Facility Name (If not institution, give street and number) <i>Johns Hopkins Bayview Center</i>		4b. City, Town, or Location of Death <i>BALTO.</i>		4c. County of Death <i>NIA</i>
Funeral Director	5. Social Security Number <i>239-92-8335</i>	6. Sex <i>1</i> M <i>2</i> F	7. Age (In yrs. last birthday) <i>49</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <i>July 20, 1951</i>		9. Birthplace (State or Foreign Country) <i>N.C.</i>		
Usual Residence of Decedent					
10a. State <i>MD.</i>		10b. County <i>NIA</i>		10c. City, Town or Location <i>BALTO.</i>	
10d. Inside City Limits <i>1</i> Yes <i>2</i> No					
10e. Street and Number <i>3623 RAVENWOOD AVE</i>			10f. Zip Code <i>21213</i>		10g. Citizen of What Country? <i>U.S.A</i>
11. Marital Status <i>1</i> Never Married <i>2</i> Married <i>3</i> Widowed <i>4</i> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <i>1</i> Yes <i>2</i> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1</i> Yes <i>2</i> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>					
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>B.S. Nurs. 19</i>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Nurse</i>		16b. Kind of Business/Industry <i>Hosp.</i>	
17. Father's Name (First, Middle, Last) <i>John Price</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Killie Coley</i>			
19e. Informant's Name/Relationship (Type, Print) <i>Tonika Coley</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3623 RAVENWOOD AVE BALTO. MD. 21213</i>			
20e. Method of Disposition <i>1</i> Burial <i>2</i> Cremation <i>3</i> Removal from State <i>4</i> Donation <i>5</i> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>WOODLAWN CEM.</i>		20c. Location - City or Town, State <i>10-19-20 BALTO. MD.</i>	
21. Signature of Funeral Service Licensee <i>Betha Bette</i>		22. Name and Address of Facility <i>Betts Funeral Home</i> <i>1129 N. CAROLINE ST. BALTO. MD. 21213</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <i>Sudden Cardiopulmonary Arrest</i>			Approximate Interval Between Onset and Death <i>Immediate</i>
Due to (or as a consequence of):		b. <i>steroid dependant asthma</i>			<i>Years</i>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		c. <i>Diabetes mellitis, Type 2</i>			<i>Years</i>
Due to (or as a consequence of):		d. <i>Hypertension</i>			<i>Years</i>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hyperlipidemia</i>					
23b. Did tobacco use contribute to the cause of death? <i>1</i> Yes <i>2</i> No <i>3</i> Probably <i>4</i> Unknown					
24a. Was an autopsy performed? <i>1</i> Yes <i>2</i> No		24b. Were autopsy findings available prior to completion of cause of death? <i>1</i> Yes <i>2</i> No			
25. Was case referred to medical examiner? <i>1</i> Yes <i>2</i> No		26. Place of Death (Check only one) Hospital: <i>1</i> Inpatient <i>2</i> ER/Outpatient <i>3</i> DOA Other: <i>4</i> Nursing Home <i>5</i> Residence <i>6</i> Other (Specify)			
27. Manner of Death <i>1</i> Natural <i>5</i> Pending investigation <i>2</i> Accident <i>6</i> Could not be determined <i>3</i> Suicide <i>4</i> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>	
28c. Injury at Work? <i>1</i> Yes <i>2</i> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) <i>1</i> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>2</i> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>Laura M Mumford</i>		29c. License number <i>D18410</i>		29d. Date signed (Month, Day, Year) <i>10/16/00</i>	
30. Name and address of person who completed cause of death (from 23a) (Type, Print) <i>Laura M Mumford, MD 10755 Falls Rd Lutherville MD 21093</i>					
31. Date filed (Month, Day, Year) <i>OCT 17 2000</i>		32. Registrar's Signature <i>Benny B Sparks</i>			



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State of Maryland / Department of Health and Mental Hygiene 00 32680

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SOOJA CALANDRA</b>		2. Date of Death Month Day Year <b>OCTOBER 11 2000</b>		3. Time of Death <b>11:57 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>The Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>148-38-4004</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>62</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>SEP 8, 1938</b>	9. Birthplace (State or Foreign Country) <b>Korea</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Anne Arundel</b>	10c. City, Town or Location <b>Severn</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>1828 Cedar Lane</b>		10f. Zip Code <b>21144</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Asian</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>Collega</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cook</b>		16b. Kind of Business/Industry <b>Food Service</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Man Jo Ahn</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Soon Ja Choi</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Millie Parrott/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4730 Hale Haven Drive Ellicott City, MD 21043</b>		
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory Inc.</b>		20c. Location - City or Town, State <b>10-14-00 Baltimore, MD</b>
	21. Signature of Funeral Service Licensee <b>Dawn McDonald</b>		22. Name and Address of Facility <b>MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
a. <b>INTRACRANIAL HEMORRAGE</b>		<b>2 DAYS</b>			
Due to (or as a consequence of):					
b. <b>BRAIN HERNIATION</b>		<b>1 DAY</b>			
Due to (or as a consequence of):					
c.					
Due to (or as a consequence of):					
d.					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA      Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Andreas R. Luft MD</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>October 11 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANDREAS R LUFT 600 N. WOLFE ST BALTIMORE MD 21287</b>					
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature <b>[Signature]</b>			

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 32681

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomas P. Carpenter				2. Date of Death Month Day Year OCT 14, 2000		3. Time of Death 7:05am	
	4e. Facility Name (If not institution, give street and number) Heritage Harbour Health & Rehab. Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 563-26-9442		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) DEC 25, 1913	
	9. Birthplace (State or Foreign Country) Mississippi		10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Annapolis	
Usual Residence of Decedent		10e. Street and Number 6303 River Crescent Drive		10f. Zip Code 21401		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Professor		16b. Kind of Business/Industry College				
17. Father's Name (First, Middle, Last) Unk. Carpenter				18. Mother's Name (First, Middle, Maiden Surname) Unk. Patten				
19e. Informant's Name/Relationship (Type, Print) Esther Carpenter/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6303 River Crescent Drive Annapolis, MD 21401				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		20c. Date 10/16/00		20d. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee Dawn F. McDonald		22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Coronary Artery Disease Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred						
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier N. J. ... M.D.				29c. License number D41978		29d. Date signed (Month, Day, Year) 10-14-2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. J. ... Hosp Dr Cheryl M.D. 20785								
31. Date filed (Month, Day, Year) OCT 17 2000		32. Registrar's Signature B. ...						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner




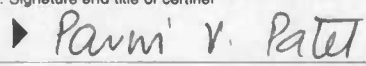



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32682

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANCES CUNNINGHAM</b>				2. Date of Death Month Day Year <b>SEPTEMBER 28 2000</b>		3. Time of Death <b>04:23 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>217 05 6422</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>3/11/14</b>	9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>
	Usual Residence of Decedent				10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. State <b>MD.</b>		10b. County		10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>USA</b>		
10e. Street and Number <b>3010 ASCENSION ST.</b>		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>AFRO</b> Specify: <b>AMERICAN</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>HOME</b>		
17. Father's Name (First, Middle, Last) <b>NICK WINSTON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LUCY WINSTON</b>				
19a. Informant's Name/Relationship (Type, Print) <b>WILLIE AMOS SISTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 1258 WEST POINT, VA. 23181</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARRISON FOREST</b>		20c. Location - City or Town, State <b>10/3/2000 OWINGS MILLS, MD.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217</b>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death <b>FEW MINUTES</b>	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b> <b>HYPERTENSION</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier 		29c. License number <b>DEA #AS 2441614-A67</b>		29d. Date signed (Month, Day, Year) <b>OCTOBER 16 2000</b>
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>PARNI PATEL MD, HARBOR HOSPITAL CENTER, 3001 S HANOVER STREET, BALTIMORE</b>				31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>				
32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner




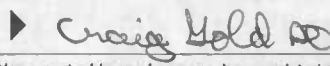
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32683

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EDITH J. CAPLAN</b>		2. Date of Death Month <b>OCTOBER</b> Day <b>13</b> Year <b>2000</b>		3. Time of Death <b>3:30 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>6900 MARSUE DRIVE #T-2</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>220-18-4164</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>OCT. 25, 1927</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MD</b>	10b. County <b>BALTIMORE</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>6900 MARSUE DRIVE #T-2</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>COURT CLERK</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry <b>DISTRICT COURT OF MD</b>		
	17. Father's Name (First, Middle, Last) <b>FRANK GREENBERG</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>LENA (UNKNOWN)</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>DAVID CAPLAN / HUSBAND</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6900 MARSUE DRIVE #T-2 BALTIMORE, MD 21215</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BETH TFILOH CEMETERY</b>		20c. Location - City or Town, State <b>10/16/00 WOODLAWN, MD</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Atherosclerotic hypertensive cardiovascular Disease</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Congestive Heart Failure</b> <b>Atrial Fibrillation</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
Medical Certification: To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>H 53088</b>		29d. Date signed (Month, Day, Year) <b>October 13, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Craig Gold DO 1838 Greenetree Road #135 Baltimore, Maryland 21208</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature 		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

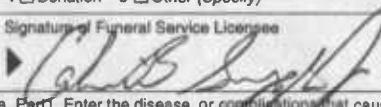

State of Maryland / Department of Health and Mental Hygiene

00 32684

Amended Item#26 per PhyG788 10/17/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lucille e. daniels</b>				2. Date of Death Month Day Year <b>OCT. 11, 2000</b>		3. Time of Death <b>9:10AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-22-2972</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>73</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT. 27, 1926</b>	
	9. Birthplace (State or Foreign Country)							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>2621 AISQUITH STREET</b>				10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>AERO-AMERICAN</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SEAMSTRESS</b>		16b. Kind of Business/Industry <b>MISTY HARBOR</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>DELOGIA CHAMBERS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LUCILLE</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>ROSA BENNETT (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4718 WILERN AVE. BALTO, MD. 21215</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		Date <b>Oct 17, 2000</b>		20c. Location - City or Town, State <b>Balto. MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213</b>			
	23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute myocardial Infarction.</b> Due to (or as a consequence of): <b>b. Coronary Artery Disease</b> Due to (or as a consequence of): <b>c. Hypertension</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>MTU</b>				29c. License number <b>D0021859</b>		29d. Date signed (Month, Day, Year) <b>10-12-2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MOHAMMAD TAQI MD 6710, HOLARING AVE Baltimore MD 21222</b>								
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32685

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Joseph Dignan, Sr.				2. Date of Death Month Day Year October 12, 2000		3. Time of Death 2:00 PM		
	4a. Facility Name (If not institution, give street and number) 7518 Ives Lane				4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 215-16-2656	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) March 27, 1920		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State Maryland	10b. County Baltimore		10c. City, Town or Location Dundalk			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 7518 Ives Lane			10f. Zip Code 21222		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 5 Years College (1-4 or 5+) College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fork Lift Operator			16b. Kind of Business/Industry Fork Lift Company		
	17. Father's Name (First, Middle, Last) Dominic Dignan				18. Mother's Name (First, Middle, Maiden Surname) Anna Dietz				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mrs. Deborah Huster (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 310 Ivy Lane Douglassville, PA 19518				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest V.A. Cem.		Date 10/16/2000		20c. Location - City or Town, State Owings Mills, MD		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>gastric bladder cancer</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>M. Portillo</i> Staff physician		29c. License number D14714		29d. Date signed (Month, Day, Year) 10/13/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MILHAEL PORTER II, JYBVM 4940 BARTON AVE, BALTIMORE, MD 21224									
31. Date filed (Month, Day, Year) OCT 17 2000		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32686

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>William John Dempsey, Jr.</i>				2. Date of Death Month Day Year <i>October 9 2000</i>		3. Time of Death <i>1702</i>	
	4a. Facility Name (If not institution, give street and number) <i>St. Agnes Health Care</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>-</i>	
Funeral Director	5. Social Security Number <i>218-22-5746</i>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>71</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>May 17 1929</i>	
	9. Birthplace (State or Foreign Country) <i>Maryland</i>		10a. State <i>MD</i>		10b. County <i>Baltimore</i>		10c. City, Town or Location <i>Baltimore</i>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <i>1559 Clairidge Road</i>		10f. Zip Code <i>21207</i>		10g. Citizen of What Country? <i>USA</i>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Auto Mechanic</i>		16b. Kind of Business/Industry <i>Auto Dealer</i>		17. Father's Name (First, Middle, Last) <i>William John Dempsey, Sr.</i>		
18. Mother's Name (First, Middle, Maiden Surname) <i>Mildred Marie Moon</i>		19a. Informant's Name/Relationship (Type, Print) <i>Joan B. Dempsey- Wife</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1559 Clairidge Road, Baltimore, Maryland 21207</i>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Woodlawn Cemetery</i>		20c. Date <i>October 13, 2000</i>		20d. Location - City or Town, State <i>Woodlawn, Maryland</i>		21. Signature of Funeral Service Licensee <i>Witzke Funeral Home, Inc.</i>		
22. Name and Address of Facility <i>630 Edmondson Avenue, Catonsville, Maryland 21228</i>		23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>RESPIRATORY FAILURE</i> Due to (or as a consequence of): <i>SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE</i> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Anthony Medical Resident</i>		
29c. License number <i>P14440</i>		29d. Date signed (Month, Day, Year) <i>OCTOBER 16 2000</i>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>ZAKARI Y. ALIYU STAGNES HOSPITAL</i>		31. Date filed (Month, Day, Year) <i>OCT 17 2000</i>		
32. Registrar's Signature <i>Benny B. Sparks</i>		33. State Registrar <i>MD</i>		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.		

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32687

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Julia Diamond</u>		2. Date of Death Month <u>October</u> Day <u>15</u> Year <u>2000</u>		3. Time of Death <u>2:25 PM</u>
	4a. Facility Name (If not institution, give street and number) <u>MILFORD MANOR NURSING HOME</u>		4b. City, Town, or Location of Death <u>BALTIMORE</u>		4c. County of Death <u>BALTIMORE</u>
Funeral Director	5. Social Security Number <u>272-10-4645</u>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>100</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <u>MAR.1,1900</u>		9. Birthplace (State or Foreign Country) <u>OH</u>		
Usual Residence of Decedent					
10a. State <u>MD</u>		10b. County <u>BALTIMORE</u>		10c. City, Town or Location <u>BALTIMORE</u>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number <u>6318 GREENSPRING AVENUE #303</u>			10f. Zip Code <u>21208</u>		10g. Citizen of What Country? <u>U.S.A.</u>
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>2</u> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>HOMEMAKER</u>		16b. Kind of Business/Industry <u>OWN HOME</u>	
17. Father's Name (First, Middle, Last) <u>ELIJAH ROSE</u>		18. Mother's Name (First, Middle, Maiden Surname) <u>ETTA DANCEAU</u>			
19a. Informant's Name/Relationship (Type, Print) <u>EARL L. DIAMOND / SON</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>11 BRANCHWOOD COURT - BALTIMORE, MD 21208</u>			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>ARLINGTON CHIZUK AMUNO</u>		20c. Location - City or Town, State <u>10/16/00 BALTIMORE, MD</u>	
21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>SOL LEVINSON &amp; BROS., INC.</u> <u>8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</u>			
23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <u>Metastatic Sarcoma</u> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <u>1 year</u>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <u></u> Due to (or as a consequence of):			
		c. <u></u> Due to (or as a consequence of):			
		d. <u></u> Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dementia</u>					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M <u></u>	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and Title of Certifier <u>[Signature]</u>		29c. License number <u>D2703Y</u>		29d. Date signed (Month, Day, Year) <u>October 15, 2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>1838 GreenTree Road Pikesville, MD 21208</u>					
31. Date filed (Month, Day, Year) <u>OCT 17 2000</u>		32. Registrar's Signature <u>[Signature]</u>			

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32688

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Emily Davis</i>				2. Date of Death Month <i>10</i> Day <i>5</i> Year <i>02</i>				3. Time of Death <i>8:10 pm</i>	
	4a. Facility Name (If not institution, give street and number) <b>JOSEPH RICHIE HOSPICE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death	
Funeral Director	5. Social Security Number <i>216-50-9531</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>52</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>3/11/48</i>		9. Birthplace (State or Foreign Country) <b>MD.</b>	
	Usual Residence of Decedent				10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County		10e. Street and Number <b>1806 W. LOMBARD ST.</b>				10f. Zip Code <b>21223</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify <b>AFRO AMERICAN</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>				16b. Kind of Business/Industry <b>HOME</b>				17. Father's Name (First, Middle, Last) <b>ROBERT DAVIS</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>FLOSSIE PUMPHREY</b>				19a. Informant's Name/Relationship (Type, Print) <b>ZANITA WILLIAMS</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1806 W. LOMBARD ST. BALTO. MD. 21223</b>	
Physician /Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEM.</b>		Date <b>10/10/2000</b>		20c. Location - City or Town, State <b>LANSDOWNE, MD.</b>			
	21. Signature of Funeral Service Licensee <i>Leola Step</i>				22. Name and Address of Facility <b>ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD 21217</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>HIV (AIDS) Infection</b>	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>William B. Sparks</i>				29c. License number <b>00017386</b>		
29d. Date signed (Month, Day, Year) <b>10-7-00</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John W. STANDIFORD, 700 GEIPE Rd., Catonsville MD 21228</b>				31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>		
32. Registrar's Signature <i>William B. Sparks</i>				33. State Registrar				34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32689

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Florence Vivian Faith</b>						2. Date of Death Month Day Year <b>Oct. 14, 2000</b>		3. Time of Death <b>8:30a.m</b>	
	4a. Facility Name (If not institution, give street and number) <b>2031 Rolling Wood Road</b>						4b. City, Town, or Location of Death <b>Catonsville</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>213-22-4487</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct 24 1920</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>2031 Rolling Wood Road</b>				10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>claims examiner</b>				16b. Kind of Business/Industry <b>Social Security</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Norman Robert Davis</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Lorraine Lominson</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Andrew Davis Faith, son</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 Fairfield Drive, Catonsville, Md. 21228</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Washington Crem.</b>		Date <b>10-18/00</b>		20c. Location - City or Town, State <b>Laurel, Md.</b>			
	21. Signature of Funeral Service Licensee <b>Shanda L Lemmer</b>		22. Name and Address of Facility <b>Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Ave., Catonsville, Md. 21228</b>							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Gangrene</b> Due to (or as a consequence of):  b. <b>Peripheral Vascular Disease</b> Due to (or as a consequence of):  c. <b>Diabetes</b> Due to (or as a consequence of):  d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier <b>Dr. M. Lomison MD</b>				29c. License number <b>D38762</b>		29d. Date signed (Month, Day, Year) <b>October 16, 2000</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Dr. Sharon McCormack, 5411 Old Frederick Rd., Suite 18, Baltimore, Md. 21229</b>									
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature <b>Sharon McCormack</b>								

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 32690

Amended Items 37, 8 per FHG 788 10/17/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John H Ford</b>				2. Date of Death Month <b>10</b> Day <b>10</b> Year <b>2000</b>		3. Time of Death <b>6:15 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Monier Health Glen Burnie</b>				4b. City, Town, or Location of Death <b>Glen Burnie</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>218-10-8583</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>6-6-14</b>	9. Birthplace (State or Foreign Country) <b>M.D.</b>	
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Glen Burnie</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>5 S. 2nd Avenue</b>				10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Lathe Operator</b>			16b. Kind of Business/Industry <b>Lumber</b>	
17. Father's Name (First, Middle, Last) <b>John Ford</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Fogerty</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Margaret M. Franke - sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 S. 2nd Avenue, Glen Burnie, MD 21061</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Cemetery</b>		Date <b>10/13</b>		20c. Location - City or Town, State <b>Glen Burnie, MD</b>		
21. Signature of Funeral Service Licensee <b>Kelly Gregory Fink</b>				22. Name and Address of Facility <b>PINK FUNERAL HOME, PA 426 Crain Hwy., SW, Glen Burnie, MD 21061</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>								Approximate Interval Between Onset and Death
23a. Immediate Cause (Final disease or condition resulting in death) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>								
23a. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23a. Due to (or as a consequence of): <b>DISEASE</b>								
23a. Due to (or as a consequence of):								
23a. Due to (or as a consequence of):								
23a. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Tasneem Lakhani</b>				29c. License number <b>D 28595</b>		29d. Date signed (Month, Day, Year) <b>10/14/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TASNEEM LAKHANI, 7220 PARK HEIGHTS AVE BALTO MD</b>								
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature <b>[Signature]</b>						





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State of Maryland / Department of Health and Mental Hygiene

00 32691

AMENDED ITEM#23a perPHYG788 101/17/2000 EW

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth Anne Gagne

2. Date of Death

October 6, 2000

3. Time of Death

7:15 a.m.

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore Co.

Funeral  
Director

5. Social Security Number

166-12-3063

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 21, 1919

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5404 Seward Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Michael Robin

18. Mother's Name (First, Middle, Maiden Surname)

Mary Hamarah

19a. Informant's Name/Relationship (Type, Print)

Mr. Raymond G. Gagne, Jr. /Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3340 E. Joppa Road Baltimore, Maryland 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stanislaus Cemetery

Date

10/9/2000

20c. Location - City or Town, State

Baltimore, Md.

21. Signature of Funeral Service Licensee

Michael E. Canapp

22. Name and Address of Facility

5305 Harford Road  
LEONARD J. RUCK, INC. Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ~~GALLBLADDER~~ CANCER OF GALLBLADDER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State  
Registrar

OCT 17 2000

Tariq Mahmood

OCTOBER 6, 2000 7:15 a.m.

Baltimore, Maryland 21215-0020

ELIZABETH GAGNE

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32692

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SHARON GREENE</b>		2. Date of Death Month Day Year <b>OCTOBER 14 2000</b>		3. Time of Death <b>1:50P</b>
	4a. Facility Name (If not institution, give street and number) <b>Bon Secour Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>095-44-1179</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>48</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>MAR 18, 1952</b>		9. Birthplace (State or Foreign Country) <b>New York</b>		
Usual Residence of Decedent					
10a. State <b>Georgia</b>		10b. County <b>Gwinett</b>		10c. City, Town or Location <b>Lawrenceville</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>3285 Haverhill Rowe</b>		10f. Zip Code <b>30044</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>		16b. Kind of Business/Industry <b>Law Firm</b>	
17. Father's Name (First, Middle, Last) <b>Richard Harris</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Charlotte Johnson</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Danielle D. Greene/daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3285 Haverhill Rowe Lawrenceville, GA 30044</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		20c. Location - City or Town, State <b>10/16/00 Baltimore, MD</b>	
21. Signature of Funeral Service Licensee <b>Dawn F. McDonald</b>		22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, MD 21228</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
a. <b>Severe Anemia</b> Due to (or as a consequence of):					
b. <b>Upper Gastrointestinal bleeding</b> Due to (or as a consequence of):					
c. <b>Liver Failure</b> Due to (or as a consequence of):					
d.					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
<b>Liver Cirrhosis</b>					
<b>Hepatitis C infection</b>					
<b>Acquired Immune Deficiency Syndrome</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>[Signature] MD.</b>		29c. License number <b>D45925</b>		29d. Date signed (Month, Day, Year) <b>10/14/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Bon Secour Hospital 2000 W. Baltimore Street, Baltimore, MD 21223</b>					
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature <b>[Signature]</b>			

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 32693

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FREDERICK WILLIAM GIANFORTE</b>				2. Date of Death Month Day Year <b>OCTOBER 13, 2000</b>		3. Time of Death <b>10:27 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>214-26-4834</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 3, 1931</b>	
	9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Randallstown</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>3726 Collier Road</b>		10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self-employed</b>		16b. Kind of Business/Industry <b>Crest Automatic Transmissions</b>				
17. Father's Name (First, Middle, Last) <b>Charles Joseph Gianforte, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Mae Metzger</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Lucille Gianforte (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3726 G. Collier Road; Randallstown, MD 21133</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lake View Cemetery</b>		20c. Location - City or Town, State <b>10/17/00 Sykesville, Maryland</b>				
21. Signature of Funeral Service Licensee <b>Joseph J. Kellner MO 0335</b>		22. Name and Address of Facility <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, MD 21133</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. VENTRICULAR FIBRILLATION</b> Due to (or as a consequence of): <b>b. ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): <b>c. HYPERTENSIVE CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>45 MINUTES</b> <b>1 HOUR</b> <b>YEARS</b>						
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D97587</b>		29d. Date signed (Month, Day, Year) <b>OCTOBER 13, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROBERT FINE, MD 5401 OLD COURT ROAD RANDALLSTOWN, MD 21133</b>								
31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>		32. Registrar's Signature <b>[Signature]</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1870-1871



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32694

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN REGINALD GREEN				2. Date of Death Month Day Year OCTOBER 12 2000		3. Time of Death 13:25	
	4a. Facility Name (If not Institution, give street and number) BALTIMORE VA HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE CITY	
Funeral Director	5. Social Security Number 219 38 4693		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 56 Yrs.		8. Date of Birth (Month, Day, Year) 2/2/44	
	9. Birthplace (State or Foreign Country) MD.		10a. State MD.		10b. County		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 2503 LAURETTA AVE.		10f. Zip Code 21223		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 7/62 7/68		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. AFRO Specify: AMERICAN		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) JANITOR		16b. Kind of Business/Industry DYNAMIC JANITORIAL CO.				
17. Father's Name (First, Middle, Last) WILLIAM H. PARKER				18. Mother's Name (First, Middle, Maiden Surname) JESSIE MAE PARKER				
19a. Informant's Name/Relationship (Type, Print) JESSIE MAE PARKER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2503 LAURETTA AVE. BALTO. MD. 21223				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISONFOREST		20c. Location - City or Town, State 10/17/2000 OWINGS MILLS, MD				
21. Signature of Funeral Service Licensee [Signature]		22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Pneumonia Due to (or as a consequence of): b. Lung Cancer Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier [Signature]		29c. License number P14666		29d. Date signed (Month, Day, Year) October 12, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL SACK BALTIMORE VA 10 North Green Street BALTIMORE, MD 21201								
31. Date filed (Month, Day, Year) OCT 16 2000		32. Registrar's Signature [Signature]						

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32695

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JANET M. HARGETT		2. Date of Death Month Day Year OCTOBER 13, 2000		3. Time of Death 12:15 PM			
	4a. Facility Name (If not institution, give street and number) 7104 AVESBURY LANE		4b. City, Town, or Location of Death FERNDAL		4c. County of Death ANNE ARUNDEL			
Funeral Director	5. Social Security Number 215-28-9027	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) AUG. 24, 1931	9. Birthplace (State or Foreign Country) NEW YORK	
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 7469 FURNACE BRANCH ROAD, APT. C				10f. Zip Code 21060		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOME CARE PROVIDER		16b. Kind of Business/Industry HEALTH CARE				
17. Father's Name (First, Middle, Last) ARTHUR A. JONES				18. Mother's Name (First, Middle, Maiden Surname) HAZEL GILBERT				
19a. Informant's Name/Relationship (Type, Print) SUSAN SMITH (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7104 AVESBURY LANE, FERNDAL, MD. 21061				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK		20c. Date 10/17/2000		20d. Location - City or Town, State GLEN BURNIE, MD.		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Chronic Pulmonary Disease Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.		Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Lung Cancer 12 yrs						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Daughter's Home						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 					29c. License number D3155	29d. Date signed (Month, Day, Year) October 16, 2000
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell W. DeLuca 1600 S. Crain Highway, Gt. Burnie, Md. 21061								
31. Date filed (Month, Day, Year) OCT 17 2000		32. Registrar's Signature 						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32696

Amended Item #23a per PHYG788 10/17/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CARROLL HARTMAN</b>				2. Date of Death Month Day Year <b>SEPTEMBER 22, 2000</b>		3. Time of Death <b>3:55 pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>HARBOR HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>216-36-1375</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>59</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 6, 1941</b>		
	9. Birthplace (State or Foreign Country) <b>Md.</b>		10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Edgemere</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>2111 Lincoln Ave.</b>		10f. Zip Code <b>21219</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9 yrs.</b>		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business/Industry <b>Baltimore City Automotive</b>			
17. Father's Name (First, Middle, Last) <b>William C. Hartman</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Rucci</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Nancy Hartman wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2111 Lincoln Ave. Edgemere Md. 21219</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sacred Heart of Jesus</b>		Date <b>Sept. 26 2000</b>		20c. Location - City or Town, State <b>Dundalk</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>METASTATIC RECTAL ADENOCARCINOMA</b>  Due to (or as a consequence of): <b><del>METASTATIC RECTAL ADENOCARCINOMA</del></b>  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>2 YEARS</b>		Approximate Interval Between Onset and Death <b>2 YEARS</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RENAL INSUFFICIENCY</b>  <b>GASTROINTESTINAL BLEEDING</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and Title of Certifier 		29c. License number <b>P14428</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 22, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>STEVE H. FUNK, MD, HARBOR HOSPITAL CENTER, 3001 S. HANOVER ST., BALTIMORE, MD 21225</b>		31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature 					

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32697

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gladys C. Hogue				2. Date of Death Month Day Year October 15, 2000		3. Time of Death 8:35 PM	
	4e. Facility Name (If not institution, give street and number) Genesis Heritage Meridian Eldercare Ctr.				4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-07-7988		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) July 24, 1907	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Edgemere	
To Be Completed by Funeral Director	10a. Street and Number 3010 Ritchie Ave.				10f. Zip Code 21219		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Baltimore County Schools Clerical			
	17. Father's Name (First, Middle, Last) Joseph A. Custer				18. Mother's Name (First, Middle, Maiden Surname) Mabel E. Krauk			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mr. Wesley C. Hogue (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 110 Victory Lane Bel Air, Maryland 21014			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. Place of Disposition (Name of cemetery, crematory or other place) Moreland Mem. Park		20c. Location - City or Town, State Baltimore, Maryland		20d. Date 10/19/2000	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Stephanie Massey				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222			
	23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. cerebro vascular Accident Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown 24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier S. Rogurej MD		29c. License number D 53720	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Rogurej, 2112 Belair Rd, Suite #9, Fallston, MD 21047				29d. Date signed (Month, Day, Year) 10/16/00			
State Registrar	31. Date filed (Month, Day, Year) OCT 17 2000		32. Registrar's Signature B. Sparks					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32698

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Allen Michael Harvey

2. Date of Death

October 12, 2000

3. Time of Death

1033 AM

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219-68-6895

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

44

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 28, 1956

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3302 Lawnview Ave

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married 2 ☐ Married  
 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

 1 ☐ Yes 2 ☒ No  
 If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

 If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

12 grade NO

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Store Keeper

16b. Kind of Business/Industry

Clerk-stores

17. Father's Name (First, Middle, Last)

Robert Davis

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Harvey

19a. Informant's Name/Relationship (Type, Print)

Nellie Wright

19b. Mailing Address (Street and Number or Rural Route Number, City or Town/State, Zip Code)

1831 N. Wolfe St. Baltimore, MD 21213

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cem

Date

10-17-2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Patricia Bette

22. Name and Address of Facility

Baltimore Funeral Home  
1129 N. Calhoun St. Baltimore, MD 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

 Immediate Cause (Final disease or condition resulting in death)  
 a. Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

 Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

 1 ☒ Natural 5 ☐ Pending investigation  
 2 ☐ Accident 6 ☐ Could not be determined  
 3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

M

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Benjamin Krpichak

29c. License number

89390

29d. Date signed (Month, Day, Year)

10/12/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Benjamin Krpichak, M.D. 40 Maryland General Hospital

31. Date filed (Month, Day, Year)

OCT 17 2000

32. Registrar's Signature

Shawn S. Sparks

State  
Registrar

Division of Vital Records, P.O. Box 68760,

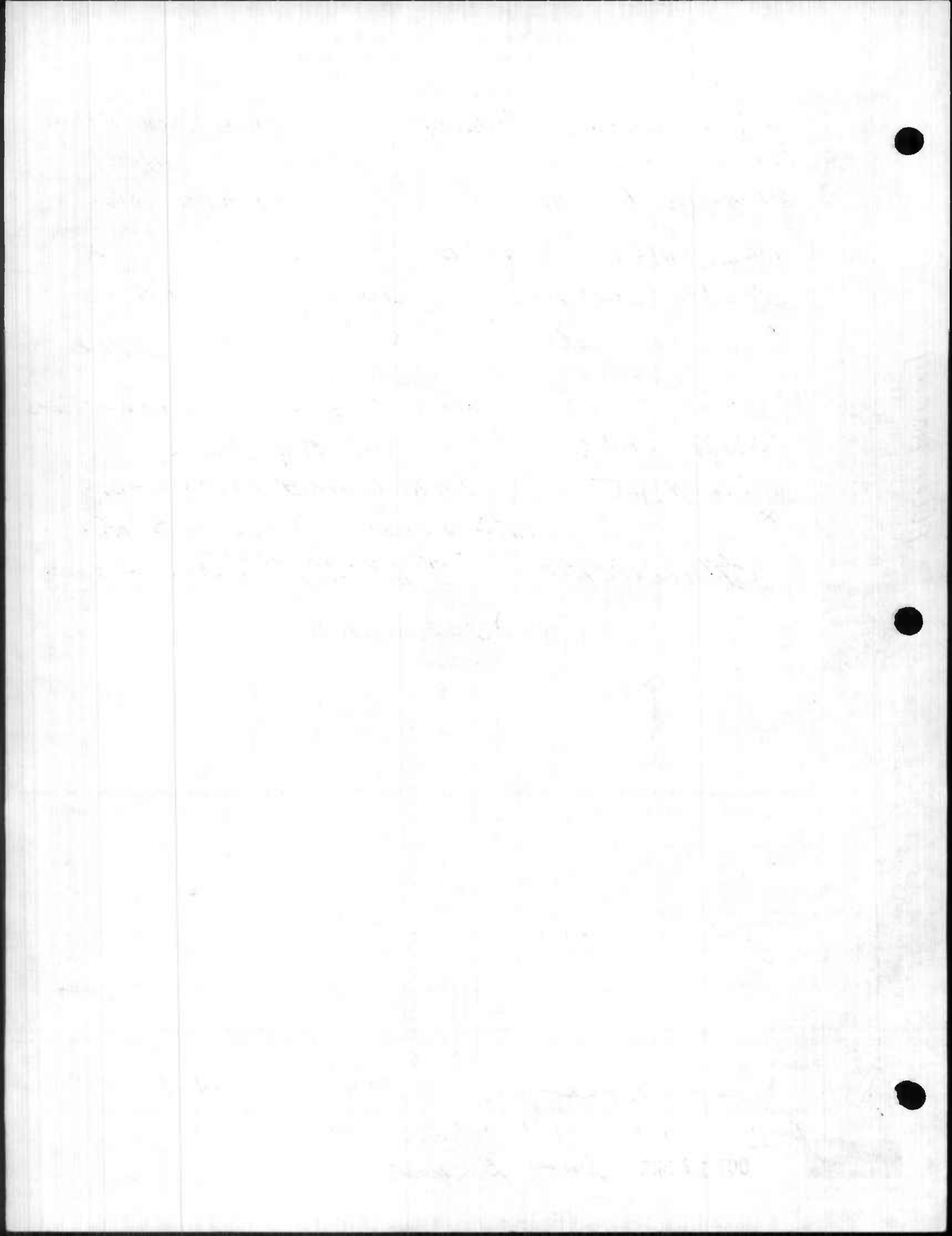
Baltimore, Maryland 21215-0020

 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Allen Harvey



00-5355-510

LOTTIE

JOHNSON Amended A Item 323 apt 11 per MEO G788 10/17/2000 EW

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32699

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lottie Lee Johnson</b>				2. Date of Death Month Day Year <b>SEPTEMBER 21, 2000</b>				3. Time of Death <b>3:16 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>6810 PARK HEIGHTS AVE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death	
Funeral Director	5. Social Security Number <b>212-44-0107</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>8-21-1943</b>		9. Birthplace (State or Foreign Country) <b>Md</b>	
	Usual Residence of Decedent									
10a. State <b>Md</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number <b>6810 Park Heights Avenue</b>				10f. Zip Code <b>21215</b>				10g. Citizen of What Country? <b>U S A</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Disabled</b>				16b. Kind of Business/Industry <b>Unk</b>		
17. Father's Name (First, Middle, Last) <b>Joseph Downs</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ella Richardson</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Eldora Christopher-Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1215 W. Mosher Street Baltimore, Md 21217</b>						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt Zion Cemetery</b>			Date <b>9-29-00</b>		20c. Location - City or Town, State <b>Lansdown, Md</b>		
21. Signature of Funeral Service Licensee <i>John B. Johnson</i>				22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Avenue Baltimore, Md 21215</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <b>INSPECTION</b> 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <i>Theodore M. King</i>				29c. License number <b>O.C.M.E.</b>				29d. Date signed (Month, Day, Year) <b>SEPTEMBER 22, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>				32. Registrar's Signature <i>Sparks</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32700

Amended Item#23a perPHYG788 10/17/2000 EW

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD CARL KRAUSE

2. Date of Death

OCTOBER 10 2000

3. Time of Death

9:32 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GOOD-SAMARITAN-HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

213-36-3894

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

61

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 24, 1938

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5925 Arizona Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

9th Grade

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Vending

17. Father's Name (First, Middle, Last)

William W. Krause

18. Mother's Name (First, Middle, Maiden Surname)

Irene T. Freiburger

19a. Informant's Name/Relationship (Type, Print)

Susan E. Krause (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5925 Arizona Avenue, Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Meadowridge Memorial Park 10/12/00 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

▶ [Signature]

22. Name and Address of Facility

Schimunek Funeral Home Inc.

3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

ESOPHAGEAL CANCER

a. ~~PERSISTENT BLEEDING GASTRITIS~~

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

~~ESOPHAGEAL CANCER~~

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ [Signature] M.D.

29c. License number

P14419

29d. Date signed (Month, Day, Year)

OCTOBER 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. ALTAHA M.D.

GOOD-SAMARITAN-HOSPITAL

BALTIMORE, MD

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 17 2000

32. Registrar's Signature

▶ [Signature]

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1971-1972

11



1971-1972

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32701

Amended Item #24a per PHYG788 10/17/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ELLA MAE KLINE				2. Date of Death Month Day Year September 29, 2000				3. Time of Death 3:00 AM		
	4a. Facility Name (If not institution, give street and number) 3118 Ferrier Road				4b. City, Town, or Location of Death Manchester				4c. County of Death Carroll		
Funeral Director	5. Social Security Number 218-32-8196		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) Apr 17, 1936		9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent										
10a. State MD		10b. County Carroll		10c. City, Town or Location Manchester				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 3118 Ferrier Road				10f. Zip Code 21102				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) caterer				16b. Kind of Business/Industry food			
17. Father's Name (First, Middle, Last) David L. Dulaney				18. Mother's Name (First, Middle, Maiden Surname) Thelma A. Schaffer							
19a. Informant's Name/Relationship (Type, Print) unk				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) GASTRIC CA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death 1 mo	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
				28d. Describe how injury occurred							
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier Flavio Kruter MD				29c. License number D35398				29d. Date signed (Month, Day, Year) 10-4-00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Flavio Kruter MD 555 S. Center ST. Westminster MD 21157											
31. Date filed (Month, Day, Year) OCT 17 2000				32. Registrar's Signature B. Sparks							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32702

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Helen Knight</i>				2. Date of Death Month: <i>OCTOBER</i> Day: <i>11</i> Year: <i>2000</i>				3. Time of Death <i>2:10 AM</i>				
	4a. Facility Name (If not institution, give street and number) <i>CHARLESTOWN CARE CENTER</i>				4b. City, Town, or Location of Death <i>CATONSVILLE</i>				4c. County of Death <i>BALTIMORE</i>				
Funeral Director	5. Social Security Number <i>215-05-5660</i>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>89</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>MAR. 6, 1911</i>		9. Birthplace (State or Foreign Country) <i>MARYLAND</i>				
	Usual Residence of Decedent				10a. State <i>MARYLAND</i>				10b. County <i>BALTIMORE</i>		10c. City, Town or Location <i>CATONSVILLE</i>		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <i>711 MAIDEN CHOICE LANE</i>				10f. Zip Code <i>21228</i>		10g. Citizen of What Country? <i>U.S.A.</i>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>WHITE</i>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9</i> College (1-4 or 5+) <i></i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>BOOKKEEPER</i>				16b. Kind of Business/Industry <i>PAINTING CONTRACTOR</i>				
	17. Father's Name (First, Middle, Last) <i>BENJAMIN WACHTER</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>MARGARET SEIBERT</i>								
	19a. Informant's Name/Relationship (Type, Print) <i>EARL KNIGHT (STEPSON)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>4804 SHOOKSTOWN ROAD, FREDERICK, MD. 21702</i>								
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>CHESAPEAKE CREMATION CENTER, LLC</i>				20c. Location - City or Town, State <i>STEVENSVILLE, MD.</i>				
	21. Signature of Funeral Service Licensee <i>Paul Hagan</i>				22. Name and Address of Facility <i>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</i>								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Pneumonia</i> Due to (or as a consequence of): <i>Alzheimer's Disease</i> Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death <i>Days</i>		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
											24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier <i>MD</i>						29c. License number <i>D47447</i>			29d. Date signed (Month, Day, Year) <i>October 11, 2000</i>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Andrew G. 711 Maiden Choice Lane Catonsville</i>													
State Registrar		31. Date filed (Month, Day, Year) <i>OCT 17 2000</i>				32. Registrar's Signature <i>Benjamin B. Sparks</i>							

ORIGINAL







AMEND ITEM: # #

Amend Items#28a-f perMEOG788 10/17/2000 EW

## Certificate of Death

Reg. No.

00 32703

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ETHEL B. LEWIS</b>				2. Date of Death Month Day Year <b>8 - 22 - 2000</b>		3. Time of Death <b>8:30 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>HARDTORD GARDEN NURSING HOME</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>1/A</b>		
Funeral Director	5. Social Security Number <b>217-03-3583</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 1, 1916</b>		
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>1/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>1832 MATZON RD.</b>				10f. Zip Code <b>21220</b>	
10g. Citizen of What Country? <b>U.S.A</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): <b>10th grade</b> College (1-4 or 5+): <b>1/A</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DOMESTIC WORKER</b>				16b. Kind of Business/Industry <b>DOMESTIC WORKER</b>				17. Father's Name (First, Middle, Last) <b>UN</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>EDITH ANDERSON</b>				19a. Informant's Name/Relationship (Type, Print) <b>REV. MELVIN TUGGLE, Jr., Minister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2 QUAIL NEST COURT - BALTIMORE, MD. 21236</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS MEM.</b>				20c. Location - City or Town, State <b>8/27/2000 ARBUTUS, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Beths Funeral Home</b>				22. Name and Address of Facility <b>1124 N. CAROLINE ST. BALTO. MD. 21213</b>				23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Smoke inhalation with collapse lung</b> Due to (or as a consequence of): <b>Peripheral vascular disease with</b> Due to (or as a consequence of): <b>Left foot gangrene</b> Due to (or as a consequence of): <b>Brucine</b>	
23b. Enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Degenerative Joint Disease</b>				23c. Enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Degenerative Joint Disease</b>				23d. Enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Degenerative Joint Disease</b>	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) <b>10-29-99</b>	
28b. Time of Injury <b>1:42 AM</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred <b>Housefire</b>	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>House</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1300 E LANE ST, Balto, Md</b>				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. Signature and title of certifier <b>M.D.</b>				29c. License number <b>D 31464</b>				29d. Date signed (Month, Day, Year) <b>8/24/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SHOAB A. HASHMI, 821 N. Eutam St Suite 308, Balto. MD 21201</b>				31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>				32. Registrar's Signature <b>B. Sparks</b>	

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 32704

Amend Item#26 perPhyG788 10/17/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jeannette M. Lindner				2. Date of Death Month Day Year October 7, 2000				3. Time of Death 8:30 am		
	4a. Facility Name (If not institution, give street and number) 203 Duncannon Road				4b. City, Town, or Location of Death Bel Air				4c. County of Death Harford		
Funeral Director	5. Social Security Number 212-34-7641		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 64 Yrs.		8. Date of Birth (Month, Day, Year) September 30, 1936		9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 5400 Hamlet Avenue				10f. Zip Code 21214				10g. Citizen of What Country? U.S.A.		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Annulment Administrator				16b. Kind of Business/Industry Catholic Church		
	17. Father's Name (First, Middle, Last) John Adam Schreiber				18. Mother's Name (First, Middle, Maiden Surname) Johanna Moeller						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Gerard M. Lindner-son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Duncannon Rd., Bel Air, MD 21014						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Most Holy Redeemer Cemetery		Date 10/11/00		20c. Location - City or Town, State Baltimore, MD				
	21. Signature of Funeral Service Licensee William G. Dau				22. Name and Address of Facility Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd., Baltimore, MD 21214						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Acute Myelogenous Leukemia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 2 years		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Son's Home							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Carol B. Miller MD				29c. License number D35254		29d. Date signed (Month, Day, Year) October 9, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carol B. Miller MD Bunting Blaustein Cancer Res Bldg 1650 Orleans St BALTIMORE MD 21231											
31. Date filed (Month, Day, Year) OCT 17 2000				32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32705

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Little</b>				2. Date of Death Month Day Year <b>Oct. 13, 2000</b>		3. Time of Death <b>12:00pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>1703 Payson Street</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>250-58-2490</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>63</b> Yrs.		8. Date of Birth Month Day Year <b>07-27-37</b>	
	9. Birthplace (State or Foreign Country) <b>SC</b>		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>1703 Payson Street</b>			
	10f. Zip Code <b>21217</b>				10g. Citizen of What Country? <b>USA</b>			
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5th Grade</b> College (1-4 or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Steel Cleaner</b>		16b. Kind of Business/Industry <b>Southern Galvanizing</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>McDuffie Gibbs</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Essie Milton</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Ruth Little</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21217</b> <b>1703 Payson Street Baltimore, Maryland</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Mem. Pk. Cem.</b>		20c. Location - City or Town, State <b>10-19-2000 Randallstown, MD</b>		21. Signature of Funeral Service Licensee <b>Lady W...</b>	
	22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C.March FH 1101 E. North Avenue</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>metastatic Prostate Cancer</b>		Approximate Interval Between Onset and Death <b>34 Months</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	29b. Signature and title of certifier <b>Janet Cooper MD</b>		29c. License number <b>D46118</b>		29d. Date signed (Month, Day, Year) <b>Oct 16 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Janet Cooper MD 1447 York Rd Lutherville MD 21093</b>	
State Registrar	31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature <b>B. Sp...</b>					

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene 00 32706

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Adda Leland</u>				2. Date of Death Month Day Year <u>October 11, 2000</u>				3. Time of Death <u>10:34pm</u>						
	4a. Facility Name (If not institution, give street and number) <u>Greater Baltimore Medical Center</u>				4b. City, Town, or Location of Death <u>Towson</u>				4c. County of Death <u>Baltimore</u>						
Funeral Director	5. Social Security Number <u>217-18-9522</u>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>81</u> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <u>April 10, 1919</u>		9. Birthplace (State or Foreign Country) <u>WV</u>		
	Usual Residence of Decedent														
10a. State <u>MD</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Timonium</u>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
10e. Street and Number <u>2300 Dulaney Valley Road</u>				10f. Zip Code <u>21093</u>				10g. Citizen of What Country? <u>USA</u>							
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <u>White</u>							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>N/A</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Secretary</u>				16b. Kind of Business/Industry <u>Insurance</u>							
17. Father's Name (First, Middle, Last) <u>Herbert K. Leland</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Elizabeth C. Heald</u>											
19a. Informant's Name/Relationship (Type, Print) <u>Donald M. Delcher/ Nephew</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>P.O. Box 5333 Timonium, MD 21094</u>											
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Druid Ridge Cemetery</u>				Date <u>Oct. 16 2000</u>		20c. Location - City or Town, State <u>Baltimore, MD</u>					
21. Signature of Funeral Home Licensee <u>Michael J. Flagle</u>				22. Name and Address of Facility <u>Lemmon Funeral Home of Dulaney Valley, Inc.</u> <u>10 W. Padonia Road Timonium, MD 21093</u>											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
Immediate Cause (Final disease or condition resulting in death) a. <u>Chronic Obstructive Pulmonary Disease</u>												years			
Due to (or as a consequence of):															
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last															
Due to (or as a consequence of):															
Due to (or as a consequence of):															
Due to (or as a consequence of):															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Atrial Flutter</u>												23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
												24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. Signature and title of certifier <u>MG Melder</u>				29c. License number <u>D51789</u>				29d. Date signed (Month, Day, Year) <u>10/13/00</u>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>MG Melder, 6565 N. Charles St, Suite 203, Towson, MD 21204</u>															
31. Date filed (Month, Day, Year) <u>OCT 17 2000</u>				32. Registrar's Signature <u>B. Sparks</u>											



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32707

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN E. MELLOR

2. Date of Death  
Month Day Year

OCTOBER 11 - 2000

3. Time of Death

10:45 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

214-20-2061

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
OCT. 17, 1921

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

SEVERN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

854 REECE ROAD

10f. Zip Code

21144

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

SALES CLERK

16b. Kind of Business/Industry

DEPARTMENT STORE

17. Father's Name (First, Middle, Last)

CHARLES

J.

GARDNER

18. Mother's Name (First, Middle, Maiden Surname)

BERTHA

SANFORD

19a. Informant's Name/Relationship (Type, Print)

RICHARD MELLOR (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1935 CODD AVENUE, BALTIMORE, MARYLAND 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MARYLAND VETERANS CEMETERY

Date

10/16/2000

20c. Location - City or Town, State

CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A.,

1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. LOBAR PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. METASTATIC BREAST CANCER

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending

investigation

2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ONABATO B 301 HOSPITAL DRIVE, GLEN BURNIE MD 21061

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 17 2000

32. Registrar's Signature

Benita B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32708

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Betty S. McCauley</b>		2. Date of Death Month <b>October</b> Day <b>15</b> Year <b>2000</b>		3. Time of Death <b>2:10 p.m.</b>
	4a. Facility Name (If not institution, give street and number) <b>3923 Wilke Avenue</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>241-30-9416</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>April 7, 1924</b>		9. Birthplace (State or Foreign Country) <b>North Carolina</b>		
Usual Residence of Decedent					
10a. State <b>Md.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore City</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3923 Wilke Avenue</b>		10f. Zip Code <b>21206</b>	
10g. Citizen of What Country? <b>United States</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Assembly Line Worker</b>		16b. Kind of Business/Industry <b>Electronics</b>			
17. Father's Name (First, Middle, Last) <b>Troy Pearce</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Lizzie Alford</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Roy C. McCauley (Husband)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3923 Wilke Avenue Baltimore, Md. 21206</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp.</b>		20c. Location - City or Town, State <b>Towson, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Milton J. Knight Jr</b>		22. Name and Address of Facility <b>Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC CANCER LUNG</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death <b>4 MONTHS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>					23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Pendelope A. Scott MD</b>		29c. License number <b>D15135</b>		29d. Date signed (Month, Day, Year) <b>OCTOBER 17, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PENDELOPE A. SCOTT MD 5601 LOCH ROSS BLVD, BALTIMORE, MD 21239</b>					
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature <b>[Signature]</b>			

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene 00 32709

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) OLIVER J MILLER				2. Date of Death Month Day Year OCTOBER 13, 2000		3. Time of Death 1526
	4a. Facility Name (If not institution, give street and number) ST. AGNES HEALTHCARE 900 CATON AVENUE				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 238-26-6795	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) SEP 22 1924	9. Birthplace (State or Foreign Country) NORTH CAROLINA
	Usual Residence of Decedent						
10a. State MARYLAND		10b. County BALTIMORE		10c. City, Town or Location BALTIMORE		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number 4005 COLBORNE ROAD				10f. Zip Code 21229		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) LABORER		16b. Kind of Business/Industry WINDOW TREATMENT	
17. Father's Name (First, Middle, Last) unknown				18. Mother's Name (First, Middle, Maiden Surname) unknown			
19a. Informant's Name/Relationship (Type, Print) Juanita Brown/Sister-in-Law				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2918 Allendale Rd., Baltimore, Maryland 21216			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GARRISON FOREST		Date 10-20-00		20c. Location - City or Town, State OWINGS MILLS, MD	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							Approximate Interval Between Onset and Death 1 hr
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number D0051965		29d. Date signed (Month, Day, Year) OCTOBER 13, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES CURTIS ST AGNES HOSPITAL BALTIMORE MD							
31. Date filed (Month, Day, Year) OCT 17 2000		32. Registrar's Signature 					

ORIGINAL

1874

1874

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State of Maryland / Department of Health and Mental Hygiene

00 32710

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Paul G. Mon		2. Date of Death Month Day Year October 13, 2000		3. Time of Death 9:00 AM
	4a. Facility Name (If not institution, give street and number) 2711 Hemlock Avenue		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 220-14-3535	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) July 23, 1921		9. Birthplace (State or Foreign Country) Maryland		
Usual Residence of Decedent					
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 2711 Hemlock Avenue			10f. Zip Code 21214		10g. Citizen of What Country? U.S.A.
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Engineer		16b. Kind of Business/Industry Aerospace	
17. Father's Name (First, Middle, Last) Alexander F. Mon			18. Mother's Name (First, Middle, Maiden Surname) Mary J. Osysko		
19a. Informant's Name/Relationship (Type, Print) Gregory Mon Sr./Son			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 901 Hackle Dr. Hampstead, Maryland 21074		
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith		20c. Location - City or Town, State 10/17/00 Baltimore, Maryland	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or brain failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. CARDIOPULMONARY ARREST Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. ATRIAL FIBRILLATION Due to (or as a consequence of): d. CHRONIC OBSTRUCTIVE LUNG DISEASE  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANTI COAGULATION (WARFARIN)					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number DO 053379		29d. Date signed (Month, Day, Year) 10/16/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NICHOLAS FLECK, MD 6940 FARMER AVE					
31. Date filed (Month, Day, Year) OCT 17 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32711

## Certificate of Death

Reg. No.

Physician  
(Medical  
Examiner)

1. Decedent's Name (First, Middle, Last)

Charles Phillip Nilan

2. Date of Death

Month Day Year  
OCT 15, 2000

3. Time of Death

10:20am

4a. Facility Name (If not Institution, give street and number)

8 North Southwood Avenue

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

101-28-8636

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
OCT 19, 1935

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8 North Southwood Avenue

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

1958-

1960

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Small Business

17. Father's Name (First, Middle, Last)

Charles Phillip Nilan

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Helen Flynn

19a. Informant's Name/Relationship (Type, Print)

Lisa Stahr/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 North Southwood Avenue Annapolis, MD 21401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

10/16/00 Baltimore, MD

21. Signature of Funeral Service Licensee

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.

299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Primary Liver Cancer / Hepato cellular cancer 5 Months  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Janet Cooper MD

29c. License number

D46118

29d. Date signed (Month, Day, Year)

Oct 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JANET COOPER MD 1447 YORK RD Lutherville MD 21093

31. Date filed (Month, Day, Year)

OCT 17 2000

32. Registrar's Signature

Benjamin A. Spotts

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
(Medical  
Examiner)

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32712

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eileen M. Newsome				2. Date of Death Month: October Day: 13, Year: 2000		3. Time of Death 6:20 AM	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 388-22-9366		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) 8/2/1925	
	9. Birthplace (State or Foreign Country) Wisconsin		10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 924 Patton Drive		10f. Zip Code 20901		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Otto Beining				18. Mother's Name (First, Middle, Maiden Surname) Unknown			
	19a. Informant's Name/Relationship (Type, Print) Steve Newsome/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 924 Patton Drive Silver Spring, Maryland 20901			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) New Cathedral Cemetery		Date 10/18/00		20c. Location - City or Town, State Baltimore, Maryland	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John C. Miller inc. 6415 Belair Road Baltimore, Maryland 21206			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Arrhythmia Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Diabetes Mellitus, Recurrent Pneumonia							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number D42518		29d. Date signed (Month, Day, Year) 10/13/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gul Chablani MD, 11119 Rockville PK, #316 Rockville, Maryland 20852							
	31. Date filed (Month, Day, Year) OCT 17 2000				32. Registrar's Signature 			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32713

Amended Item#23a per PHY 788 10/17/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HERMAN PENNICK</b>		2. Date of Death Month Day Year <b>OCTOBER 6<sup>th</sup> 2000</b>		3. Time of Death <b>2:48 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>149-16-7612</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>AUG. 11, 1925</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>
	10c. City, Town or Location <b>BALTIMORE CITY</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10a. Street and Number <b>6116 BELAIR ROAD</b>		10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>USA.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>				
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10<sup>th</sup> GRADE</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>GROUNDSMEN</b>		16b. Kind of Business/Industry <b>PARKS &amp; RECREATION</b>
	17. Father's Name (First, Middle, Last) <b>GEORGE PENNICK</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>PINKEY ESTELLE CURTIS</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>KEITH PENNICK (SON)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2712 N. ROSEDALE AVE. BALTO, MD. 21216</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARBUTUS CEMETERY</b>		20c. Location - City or Town, State <b>10-11-00 BALTIMORE, MARYLAND</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIMORE MD. 21217</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): <b>b. METASTATIC CARCINOMA OF THE PROSTATE</b> Due to (or as a consequence of): <b>c. METASTATIC CARCINOMA OF PROSTATE</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>William M. M.S.</b>		29c. License number <b>P13457</b>		29d. Date signed (Month, Day, Year) <b>OCT. 06, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROSEMARIE MARAI 90 GOOD SAMARITAN HOSPITAL 5601 COCH RUN BLVD, BALT MD 21239</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner






Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32714

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Stephen Barry Pratt				2. Date of Death Month Day Year October 15, 2000		3. Time of Death 1:20 AM	
	4a. Facility Name (If not institution, give street and number) Atlantic General Hospital				4b. City, Town, or Location of Death Berlin		4c. County of Death Worcester	
Funeral Director	5. Social Security Number 212-80-4511	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 42 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan. 30, 1958		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore City			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number 3903 Foster Avenue				10f. Zip Code 21224		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Truck Driver		16b. Kind of Business/Industry Trucking Industry		
17. Father's Name (First, Middle, Last) Curtis Owen Pratt				18. Mother's Name (First, Middle, Maiden Surname) Jessie Luella Smith				
19a. Informant's Name/Relationship (Type, Print) Mrs. Barbara A. Pratt (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3903 Foster Ave. Baltimore, Maryland 21224				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park		Date 10/19/2000		20c. Location - City or Town, State Dorsey, Maryland	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222				
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Myocardial Infarction Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HIN								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number D42908		29d. Date signed (Month, Day, Year) 10/16/00		
30. Name and address of person who completed cause of death (Item 29b) (Type, Print) David Schardt, MD 808 S. Conkling St. Balt, MD 21224								
31. Date filed (Month, Day, Year) OCT 17 2000				32. Registrar's Signature 				

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32715

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BETTIE MARIE PARKER</b>				2. Date of Death Month Day Year <b>October 16 2000</b>		3. Time of Death <b>04:00 AM</b>	
	4e. Facility Name (If not institution, give street and number) <b>The Johns Hopkins Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-14-8686</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b>	8. Date of Birth (Month, Day, Year) <b>OCT 24 1913</b>	9. Birthplace (State or Foreign Country) <b>N.C.</b>			
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>md</b>	10b. County <b>NIA</b>	10c. City, Town or Location <b>BALTO</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>2025 E. LANVALE ST.</b>			10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 grade</b> College (1-4 or 5+) <b>1 yr.</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BALTO. CITY School System</b>		16b. Kind of Business/Industry			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>JAMES ALSTON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ROXANNA HARRIS</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>IOLA BENTON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5005 PLYMOUTH RD., BALTO. MD</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARbutus MEM PK.</b>		20c. Location - City or Town, State <b>10-20-200 Arbutus MD.</b>			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>CATHY FURBER/HARVEY 1834 CAROLINE ST. BALTO. MD 21213</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ADENOCARCINOMA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____ Due to (or as a consequence of):</b> <b>c. _____ Due to (or as a consequence of):</b> <b>d. _____ Due to (or as a consequence of):</b>						Approximate Interval Between Onset and Death <b>UNKNOWN</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier <i>[Signature]</i>	
	29c. License number <b>RES-000</b>						29d. Date signed (Month, Day, Year) <b>10/16/2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ANASTASIOS P. SALIARIS, JOHN HOPKINS HOSPITAL, TOWER 110, BALTIMORE MD 21287</b>							
	31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32716

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT DANIEL PFEIFFER, JR.

2. Date of Death

Month Day Year  
OCTOBER 16 2000

3. Time of Death

9:27 AM

4a. Facility Name (If not Institution, give street and number)

EASTPOINT NURSING HOME

4b. City, Town, or Location of Death

ESSEX

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

219-18-7245

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 30, 1924

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

225 S. WASHINGTON STREET

10f. Zip Code

21231

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1943-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

SUPERVISOR

16b. Kind of Business/Industry

CARR-LOWREY GLASS

17. Father's Name (First, Middle, Last)

ROBERT D. PFEIFFER, SR.

18. Mother's Name (First, Middle, Maiden Surname)

FLORENCE E. RITTER

19a. Informant's Name/Relationship (Type, Print)

NANCY PFEIFFER/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

225 S. WASHINGTON STREET, BALTIMORE, MARYLAND 21231

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE NAT'L CEM.

Date

10/19/00

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LILLY &amp; ZEILER INC. FUNERAL HOME

1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21231

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cerebrovascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CANCER OF LUNG

C.A.D.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D45757

29d. Date signed (Month, Day, Year)

Oct 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATTHEW MONAHAN 5505 HOPKINS BAYVIEW LINDS BAY 21224

31. Date filed (Month, Day, Year)

OCT 16 2000

32. Registrar's Signature

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
important: If item 27 is marked other than "natural", or items 23e or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32717

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician / Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician / Medical Examiner	1. Decedent's Name (First, Middle, Last) CECIL BETHLEHAM RAGSDALE			2. Date of Death Month Day Year OCTOBER 13, 2000		3. Time of Death 3:45 AM
	4e. Facility Name (If not institution, give street and number) ANNAPOLIS REHABILITATION CENTER			4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL
Funeral Director	5. Social Security Number 217-24-4549	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	8. Date of Birth (Month, Day, Year) DEC. 26, 1929	9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent					
10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location CROWNSVILLE		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10e. Street and Number 1090 PLUM CREEK DRIVE			10f. Zip Code 21032		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1950-1954		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) REFUSE REMOVAL			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) REFUSE REMOVAL		16b. Kind of Business/Industry SANITATION	
17. Father's Name (First, Middle, Last) CECIL B. RAGSDALE			18. Mother's Name (First, Middle, Maiden Surname) MYRTLE SPICER			
19a. Informant's Name/Relationship (Type, Print) DAVID RAGSDALE (SON)			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1090 PLUM CREEK DRIVE, CROWNSVILLE, MD. 21032			
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MARYLAND VETERANS CROWNSVILLE		20c. Location - City or Town, State CROWNSVILLE, MD.		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <u>lung cancer, metastatic</u> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____						Approximate Interval Between Onset and Death 6 months
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier 			29c. License number D29571		29d. Date signed (Month, Day, Year) 10/13/00	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Paul Berez, MD 1655 Crofton Blvd #01 Crofton, MD 21114						
State Registrar	31. Date filed (Month, Day, Year) OCT 17 2000		32. Registrar's Signature 			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND#23C&amp;D &amp;#27 PER MD. G789 11-2-2000 JAB

State of Maryland / Department of Health and Mental Hygiene

00 32718

Amended Item#26 per PHYG788 10/11/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MATTIE ROSE BOROUGH</b>				2. Date of Death Month Day Year <b>SEPT. 17 2000</b>		3. Time of Death <b>1719</b>		
	4a. Facility Name (If not institution, give street and number) <b>3800 W. BELVEDERE AVE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>218 22 1730</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JUNE 18, 1912</b>		9. Birthplace (State or Foreign Country) <b>S. Carolina</b>	
	Usual Residence of Decedent								
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10a. Street and Number <b>3800 W. BELVEDERE AVE #1006</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th grade</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>		16b. Kind of Business/Industry <b>Private family</b>			
17. Father's Name (First, Middle, Last) <b>WILLIAM TORRENCE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>EMMA DOUGLAS</b>					
19a. Informant's Name/Relationship (Type, Print) <b>JUANITA ROSE BOROUGH / Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3926 MORTIMER AVE BALTIMORE, MARYLAND</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREENMOUNT CEMETERY</b>		Date <b>9/23/2000</b>		20c. Location - City or Town, State <b>BALTIMORE, MARYLAND</b>			
21. Signature of Funeral Service Licensee <b>Larry Hall</b>				22. Name and Address of Facility <b>CHATHAM - HARRIS Funeral Home 5240 REISTERSTOWN ROAD BALTIMORE, MARYLAND 21215</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Atherosclerotic CARDIOVASCULAR disease</b> Many years Due to (or as a consequence of):  b. <b>Hyperlipidemia</b> many years Due to (or as a consequence of):  c. <b>POOR EATING HABITS</b> many years Due to (or as a consequence of):  d. <b>POOR / INADEQUATE NUTRITIONAL INFORMATION</b> many years  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>								Approximate Interval Between Onset and Death	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier <b>Anthony Joseph M.D.</b>	
29c. License number <b>DO047529</b>								29d. Date signed (Month, Day, Year) <b>9/21/00</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ANTHONY JOSEPH M.D., 4120 PATTERSON AVE, BALTIMORE, MD 21223</b>									
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>				32. Registrar's Signature <b>[Signature]</b>					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32719

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WESLEY V ROACH, SR.</b>				2. Date of Death Month <b>10</b> Day <b>07</b> Year <b>2000</b>		3. Time of Death <b>10:52</b>														
	4a. Facility Name (If not institution, give street and number) <b>HOWARD COUNTY GENERAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>COLUMBIA</b>		4c. County of Death <b>HOWARD</b>														
Funeral Director	5. Social Security Number <b>084-42-6703</b>		6. Sex <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>54</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 20, 1946</b>														
	9. Birthplace (State or Foreign Country) <b>West Indies</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>														
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>4405 Groveland Avenue</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>														
	11. Marital Status <b>2</b> <input checked="" type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>2</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>2</b> <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>														
	15. Decedent's Education (Specify only highest grade completed) <b>2</b> Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesman</b>		16b. Kind of Business/Industry <b>Auto Industry</b>																
	17. Father's Name (First, Middle, Last) <b>Vernon T. Roach</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nellie Eversley</b>																
	19a. Informant's Name/Relationship (Type, Print) <b>Marjorie K. Roach / wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4405 Groveland Ave., Baltimore, Maryland 21215</b>																
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore/Washington Crem.</b>		Date <b>Oct. 13, 2000</b>		20c. Location - City or Town, State <b>Laurel, Maryland</b>														
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Witzke Funeral Home, Inc. 5555 Twin Knolls Rd., Columbia, Maryland 21045</b>																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
	<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>BACTERIAL ENDOCARDITIS</b></td> <td>Approximate Interval Between Onset and Death <b>2 weeks.</b></td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>BACTERIAL ENDOCARDITIS</b>	Approximate Interval Between Onset and Death <b>2 weeks.</b>	b.	Due to (or as a consequence of):		c.	Due to (or as a consequence of):		d.	Due to (or as a consequence of):	
	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>BACTERIAL ENDOCARDITIS</b>	Approximate Interval Between Onset and Death <b>2 weeks.</b>																	
b.		Due to (or as a consequence of):																			
c.		Due to (or as a consequence of):																			
d.		Due to (or as a consequence of):																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>1. SARCOIDOSIS.</b> <b>2. CVA.</b> <b>3. GI BLEED.</b> <b>4. CHRONIC RENAL INSUFFICIENCY.</b>																					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. Manner of Death <b>1</b> <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)																	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																					
29b. Signature and title of certifier  MD				29c. License number <b>D0050235</b>		29d. Date signed (Month, Day, Year) <b>10/7/00.</b>															
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>FRED A. PADDER, MD 11805, Little Patuxent Pkwy, Suite 101, COLUMBIA, MD 21044.</b>																					
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature 																			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,




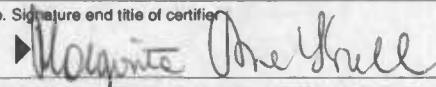

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32720

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LUIS F. GABRIEL RAMIREZ</b>			2. Date of Death Month <b>October</b> Day <b>13</b> Year <b>2000</b>		3. Time of Death <b>9:10 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>919 South Oldham Street</b>			4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>230-65-9054</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>23</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JULY 23, 1977</b>	
	9. Birthplace (State or Foreign Country) <b>MEXICO</b>		10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>919 SOUTH OLDHAM STREET</b>		10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>MEXICO</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>MEXICAN</b>		14. Race - American Indian, Black, White, etc. Specify: <b>HISPANIC</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DISH WASHER</b>		16b. Kind of Business/Industry <b>RESTAURANT</b>				
17. Father's Name (First, Middle, Last) <b>FELIX GABRIEL</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>VIRGILIA RAMIREZ</b>						
19a. Informant's Name/Relationship (Type, Print) <b>ARTURO GARCIA ORTIZ</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>919 SOUTH OLDHAM ST., BALTIMORE, MD. 21224</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CEMENTERIO MUNICIPAL</b>		Date <b>10/22/00</b>		20c. Location - City or Town, State <b>TAPACHULA CHIAPAS, MEXICO</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>CHARLES S. ZEILER &amp; SON, INC. 6224 EASTERN AVE., BALTIMORE, MD. 21224</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>Acute Alcohol Intoxication</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <u>at scene</u>						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Found: 10-13-2000</b>		28b. Time of Injury <b>Found: 9:00 A M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred <b>Subject ingested alcohol.</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Found: Row House</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Found: 919 Oldham Street, Baltimore, Maryland.</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>October 14, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,







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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32721

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SANDRA L SIMPKINS

2. Date of Death

OCT 16 2000

3. Time of Death

0330

4a. Facility Name (If not Institution, give street and number)

ST AGNES HOSPITAL

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-64-6295

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 12, 1954

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Howard

10c. City, Town or Location

Elkridge

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6636 Highland Avenue

10f. Zip Code

21075

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Assembler

16b. Kind of Business/Industry

Ciena Corp.

17. Father's Name (First, Middle, Last)

Frank William Jackson

18. Mother's Name (First, Middle, Maiden Surname)

Doris Elizabeth Wingate

19a. Informant's Name/Relationship (Type, Print)

Wayne Cooper - Boyfriend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6636 Highland Avenue, Elkridge, Md. 21075

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Mem. Park

Date

10/19/00

20c. Location - City or Town, State

Elkridge, Md.

21. Signature of Funeral Service Licensee

M. K. Marshall

22. Name and Address of Facility

Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.  
7250 Washington Blvd., Elkridge, Md. 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Approximate Interval Between Onset and Death

5 1/2 hours

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Frederick Kuhn MD

29c. License number

036336

29d. Date signed (Month, Day, Year)

OCT 16 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick Kuhn MD ST AGNES HOSPITAL

31. Date filed (Month, Day, Year)

OCT 17 2000

32. Registrar's Signature

Benjamin B. Sparks

State Registrar

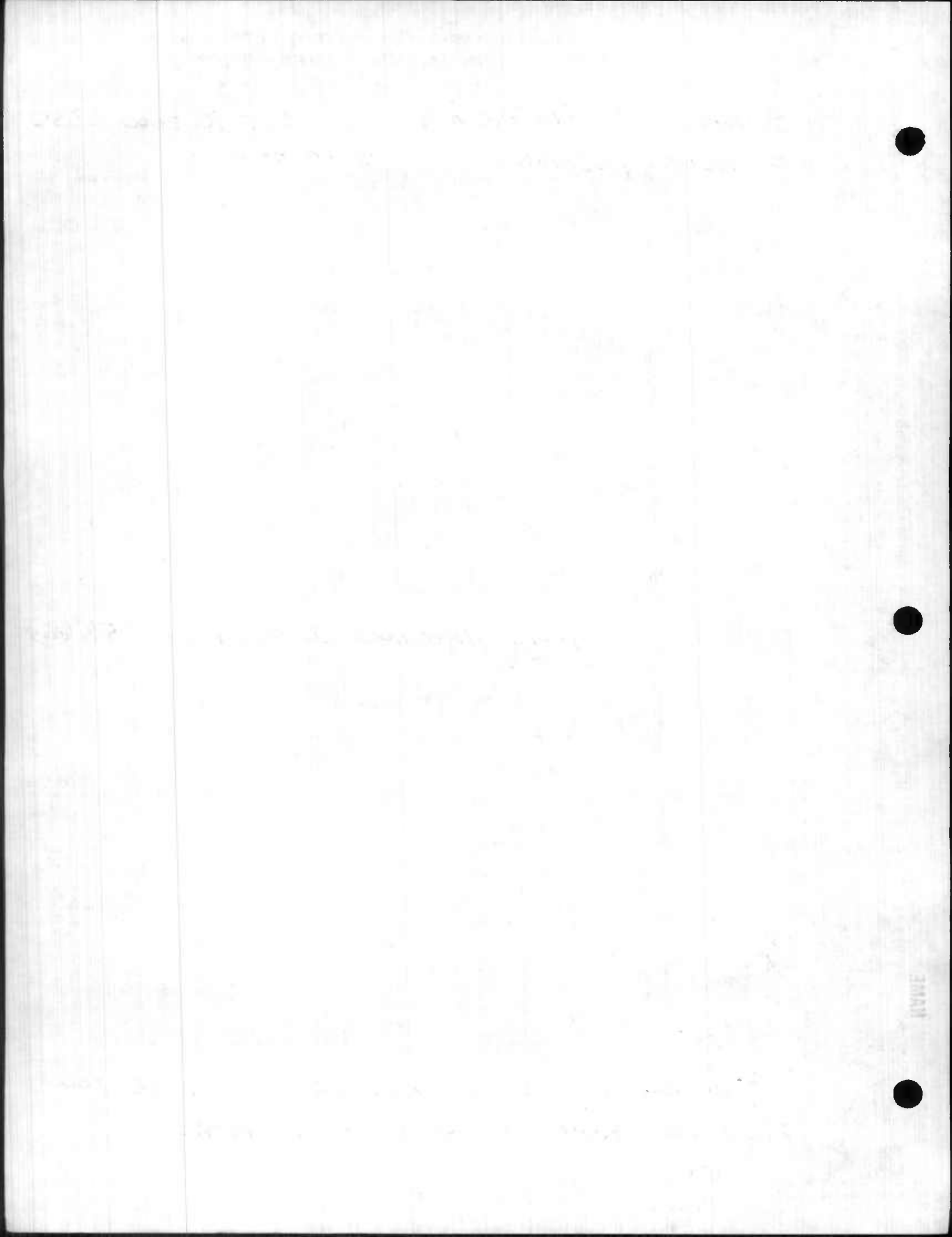
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME  
Division of Vital Records, P.O. Box 68760,To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32722

Amended Item#8 per ABG788 10/17/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIRGINIA SOMMER</b>				2. Date of Death Month <b>October</b> Day <b>6</b> Year <b>2000</b>				3. Time of Death <b>2:04 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>GEC - RANDALLSTOWN</b>				4b. City, Town, or Location of Death <b>Randallstown</b>				4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>219-01-5957</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>2-21-1919</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
	10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Randallstown</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>9109 Liberty Road</b>					10f. Zip Code <b>21133</b>			10g. Citizen of What Country? <b>USA</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>					18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>typist</b>			16b. Kind of Business/Industry <b>unk</b>			
17. Father's Name (First, Middle, Last) <b>unk</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>unk</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Genesis Randallstown</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9109 Liberty Rd Randallstown, MD 21133</b>						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>				20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State					
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>					22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>									Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SCHIZOPHRENIA; HYPOTHYROIDISM</b> <b>ABDOMINAL AORTIC ANEURYSM</b>									23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <b>Wandrus</b>					29c. License number <b>DS2360</b>			29d. Date signed (Month, Day, Year) <b>10/6/00</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>ICUBIN SANDHU</b> <b>1838 GREENE TREE RD. SUITE 300 PIKESVILLE MD 21208</b>											
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>					32. Registrar's Signature <b>Beverly B. Sparks</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32723

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MINDELLA SCOTT</b>				2. Date of Death Month Day Year <b>OCTOBER 16, 2000</b>		3. Time of Death <b>11:28am</b>		
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL OF BALTIMORE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>NA</b>		
Funeral Director	5. Social Security Number <b>213-20-7939</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>98 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>JANUARY 26, 1902</b>		
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>BALTIMORE</b>		
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>3939 PENHURST AVENUE</b>				
	10f. Zip Code <b>21215</b>				10g. Citizen of What Country? <b>USA</b>				
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. <b>AFRICAN AMERICAN</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NURSES AIDE</b>		16b. Kind of Business/Industry <b>HEALTH CARE</b>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>CHARLES SCOTT</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ANNIE LEE</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>CARLA RANSON (GUARDIAN)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>34 MARKET PLACE SUITE 300 BALTIMORE MD 21202</b>				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MOUNT ZION CEMETERY</b>		20c. Location - City or Town, State <b>10/18/00 LANSDOWNE, MD</b>		20d. Date		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217</b>						
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>SEPTIC SHOCK</b> Due to (or as a consequence of): <b>PNEUMONIA</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>CEREBRAL VASCULAR ACCIDENT</b> <b>CARDIAC ARRHYTHMIAS</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 				29c. License number <b>RES 000</b>		29d. Date signed (Month, Day, Year) <b>OCTOBER 16, 2000</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PALLAVI SHAH, D.O. 2401 WEST BELVEDERE AVENUE, BALTIMORE, MD 21215</b>								
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature 						
	State Registrar								

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item #24a per PHYg788 10/17/2000 EW

## Certificate of Death

Reg. No.

00 32724

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen A. Sheehan</b>				2. Date of Death Month <b>10</b> Day <b>01</b> Year <b>00</b>			3. Time of Death <b>3:15 AM</b>					
	4a. Facility Name (If not institution, give street and number) <b>Mariner Health Catonsville</b>				4b. City, Town, or Location of Death <b>Catonsville</b>			4c. County of Death <b>Baltimore</b>					
Funeral Director	5. Social Security Number <b>352-05-1723</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>93</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug 1, 1907</b>		9. Birthplace (State or Foreign Country) <b>ILL</b>				
	10e. State <b>MD</b>				10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>98 Smithwood Street</b>				10f. Zip Code <b>21228</b>			10g. Citizen of What Country? <b>USA</b>						
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>secretary</b>			16b. Kind of Business/Industry <b>real estate</b>						
17. Father's Name (First, Middle, Last) <b>George Lynn</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Anna Fischer</b>								
19a. Informant's Name/Relationship (Type, Print) <b>James Linsley/son</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9406 Joey Drive Ellicott City, MD 21043</b>								
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)			20c. Location - City or Town, State						
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>					22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive Heart Failure</b> Due to (or as a consequence of): <b>b. Atrial Fibrillation</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b> Due to (or as a consequence of):										Approximate Interval Between Onset and Death <b>unknown</b> <b>unknown</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred			
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29c. License number <b>D26307</b>		29d. Date signed (Month, Day, Year) <b>10-2-00</b>	
29b. Signature and title of certifier <b>Rani S. Karipinen M.D.</b>													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RANI S. KARIPINEN 4000 ANNAPOLIS RD, BALTIMORE, MD 21227</b>													
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>				32. Registrar's Signature <b>B. Sparks</b>									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

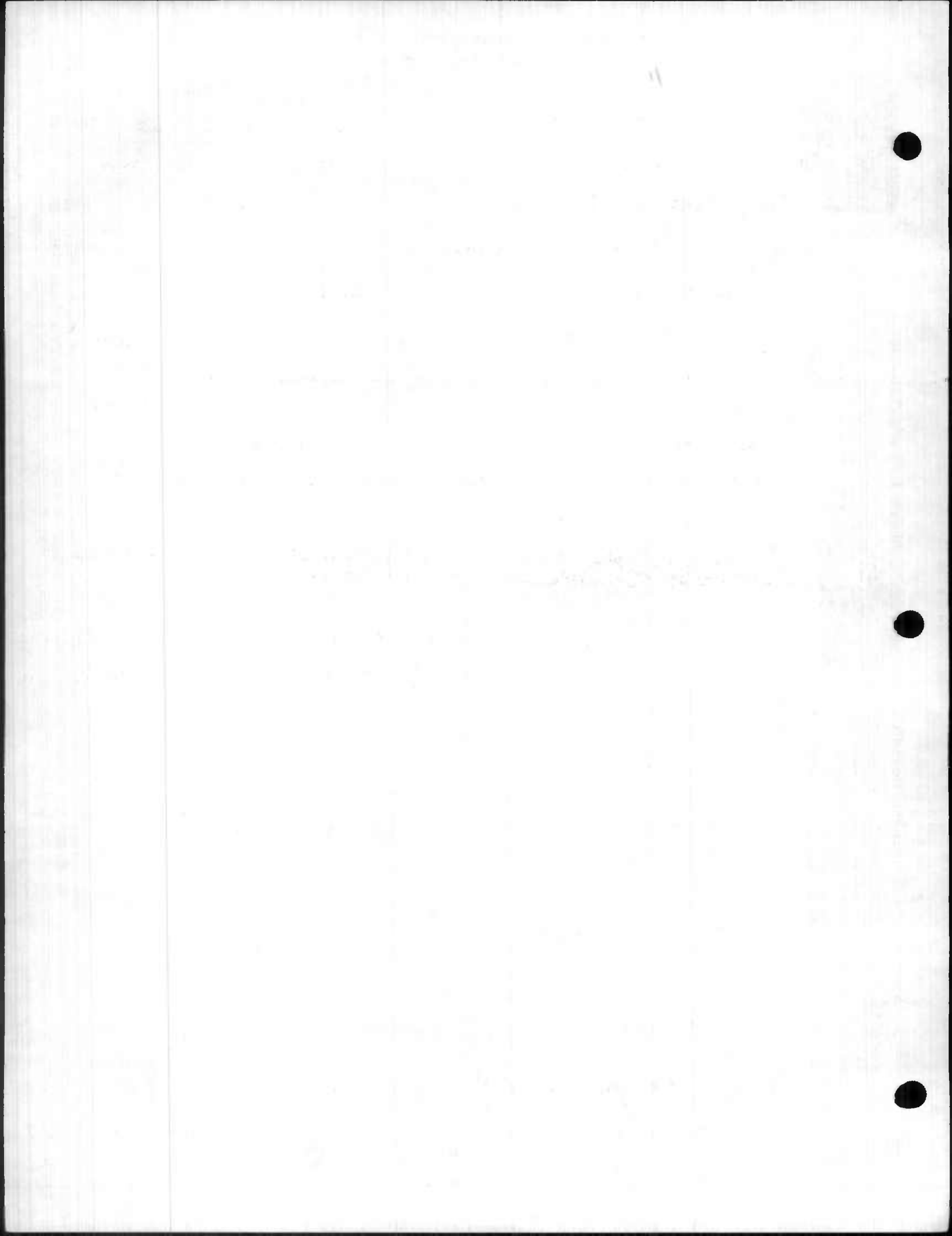
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last) CLARA VIRGINIA STEPHAN

2. Date of Death Month Day Year OCTOBER 13, 2000

3. Time of Death 7:27 AM

4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death ANNAPOLIS

4c. County of Death ANNE ARUNDEL

5. Social Security Number 218-36-5229

6. Sex 1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday) 91 Yrs.

8. Date of Birth (Month, Day, Year) FEB. 27, 1909

9. Birthplace (State or Foreign Country) MARYLAND

10a. State MARYLAND

10b. County ANNE ARUNDEL

10c. City, Town or Location PASADENA

10d. Inside City Limits 1 ☐ Yes 2 ☒ No

10e. Street and Number 363 NORTH SHORE ROAD

10f. Zip Code 21122

10g. Citizen of What Country? U.S.A.

11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CANDY SALESPERSON

16b. Kind of Business/Industry CANDY

17. Father's Name (First, Middle, Last) ELLSWORTH STICKELL

18. Mother's Name (First, Middle, Maiden Surname) CLARA FORD

19a. Informant's Name/Relationship (Type, Print) JACK E. STEPHAN (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 363 NORTH SHORE ROAD, PASADENA, MARYLAND 21122

20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEMORIAL PARK

20c. Location - City or Town, State GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) e. Arteriosclerotic Cardiovascular Disease 5 yrs.

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D41927

29d. Date signed (Month, Day, Year) 10-13-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jorge Peter-Alan, MD 3708 Mountain Rd Pasadena, MD 21122

31. Date filed (Month, Day, Year) OCT 17 2000

32. Registrar's Signature

State Registrar

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. If the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.



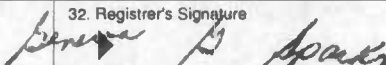
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32726

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Richard B. Shock</b>				2. Date of Death Month Day Year <b>Oct. 12, 2000</b>				3. Time of Death <b>7:20 AM</b>					
	4a. Facility Name (If not institution, give street and number) <b>3017 Reckord Road</b>				4b. City, Town, or Location of Death <b>Fallston</b>				4c. County of Death <b>Harford</b>					
Funeral Director	5. Social Security Number <b>214-26-1013</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b>		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>Sept 18, 1930</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent													
10a. State <b>MD</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Fallston</b>								10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>3017 Reckord Road</b>				10f. Zip Code <b>21047</b>				10g. Citizen of What Country? <b>USA</b>						
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korean Conflict</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>white</b>						
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10years</b> College (1-4or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>				16b. Kind of Business/Industry <b>Spencer Sand &amp; Gravel Co.</b>						
17. Father's Name (First, Middle, Last) <b>Charles Shock</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Helena Brooks</b>										
19a. Informant's Name/Relationship (Type, Print) <b>Beth D. Shock (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3017 Reckord Rd Fallston, MD 21047</b>										
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BelAir Memorial Gardens</b>				Date <b>11/16/2000</b>		20c. Location - City or Town, State <b>BelAir, MD</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>E.F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md 21087</b>										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. <i>Carcinoma lung</i></b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>												Approximate Interval Between Onset and Death <b>2 years</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <b>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b>				
										24a. Was an autopsy performed? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>				
										24b. Were autopsy findings available prior to completion of cause of death? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>				
25. Was case referred to medical examiner? <b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>		28d. Describe how injury occurred				
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier  <b>MD</b>				29c. License number <b>D18487</b>				29d. Date signed (Month, Day, Year) <b>10/24/00</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MYO THANT 6830 HOSPITAL DRIVE, BALTO, MD 21237</b>														
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>				32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32727

AMEND#10ePER F.H. G788 10-16-2000 JAB

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

EMMA

SAVOY

2. Date of Death

Month Day Year  
OCTOBER 13 2000

3. Time of Death

4 25 AM

4a. Facility Name (If not institution, give street and number)

BON SECOURS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A.

5. Social Security Number

218-01-2724

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct 5 1908

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A.

10c. City, Town or Location

BALTO.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5215 SAYBROOK RD.

10f. Zip Code

21206

10g. Citizen of What Country?

USA.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

High School

College (1-4 or 5+)

NO

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

MT-Vernon Club

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Joseph BARRETT

18. Mother's Name (First, Middle, Maiden Surname)

EDNA Unknown

19a. Informant's Name/Relationship (Type, Print)

Barbara Royster

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5215 SAYBROOK RD BALTO MD 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Crownsville VA Cem

Date

10-19-2000 Crownsville Md.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Patricia Batts

22. Name and Address of Facility

Batts Funeral Home NO.  
1294 CHARLTON ST. BALTO. 2121023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Atrial Fibrillation

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. Seizure disorder

Due to (or as a consequence of):

d. Cerebral vascular accident

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic anemia

Dysphagia

Gouty arthritis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Patricia Batts

29c. License number

030115

29d. Date signed (Month, Day, Year)

10/16/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. Ohiokpena, MD 2600 LIBERTY HTS AVE BALTIMORE MD 21215

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 17 2000

32. Registrar's Signature

Benjamin B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32728

AMEND ITEM: 16A PER F.H. G788 10-17-00 WR.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KATHARINE MAY SCALONE</b>				2. Date of Death Month: <b>10</b> Day: <b>13</b> Year: <b>2000</b>		3. Time of Death <b>5:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>2823 PINEWOOD AVE.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE CITY</b>	
Funeral Director	5. Social Security Number <b>215-56-0783</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>11/26/22</b>	
	10e. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>2823 PINEWOOD AVE.</b>				10f. Zip Code <b>21214</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10<sup>TH</sup> GRADE</b> College (1-4 or 5+) <b>N/A</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SECRETARY</b>		16b. Kind of Business/Industry <b>KIDNEY FOUNDATION</b>	
	17. Father's Name (First, Middle, Last) <b>MARTIN MAYFORT JR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CLARA MAY CROSS</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>JOSEPH P. SCALONE/HUSBAND</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2823 PINEWOOD AVE BALTO. MD. 21214</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARDENS OF FAITH</b>		Date <b>10/17/00</b>		20c. Location - City or Town, State <b>BALTO. MD.</b>	
	21. Signature of Funeral Service Licensee <b>ROBERT C. ALTENBURG</b>				22. Name and Address of Facility <b>ALTENBURG FUNERAL HOME, P.A. 6009 HARTFORD ROAD BALTIMORE, MD 21214</b>			
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>LUNG CANCER</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death <b>ONE YEAR</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Michael Molinsky MD</b>				29c. License number <b>D0056319</b>		29d. Date signed (Month, Day, Year) <b>10/16/00</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MICHAEL MOLINEUX MD 9105 FRANKLIN SQUARE DR. BALTIMORE, MARYLAND 21237</b>								
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>				32. Registrar's Signature <b>Bevera B. Sparks</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32729

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>LIDIA MELANIA SHAVIAK</b>		2. Date of Death Month Day Year <b>Oct. 8, 2000</b>		3. Time of Death <b>10 p.m.</b>	
4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>219-32-1809</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Feb. 13, 1908</b>	9. Birthplace (State or Foreign Country) <b>UKRAINE</b>	
Usual Residence of Decedent					
10a. State <b>MD.</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>2217 E. LOMBARD STREET</b>		10f. Zip Code <b>21231</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>PIANO TEACHER</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SELF EMPLOYED</b>	
17. Father's Name (First, Middle, Last) <b>WOLODYMYR MRVC</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>CHRYSTYNA MRVC</b>			
19a. Informant's Name/Relationship (Type, Print) <b>LILLIANA PASLAWSKYJ/ DAUGHTER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13 LYONSVILLE ROAD, BOONTON, NEW JERSEY 07005</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. MICHAEL'S UKRAINIAN</b>		20c. Location - City or Town, State <b>10/12/00 BALTIMORE, MARYLAND</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>LILLY &amp; ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21231</b>			
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>pneumonia</b>		Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. _____		Due to (or as a consequence of):	
		c. _____		Due to (or as a consequence of):	
		d. _____		Due to (or as a consequence of):	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>8-18151</b>		29d. Date signed (Month, Day, Year) <b>10-9-2000</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Chi-Shiang Chen, M.D. 301 St. Paul Place Suite 409, Baltimore, Maryland 21202</b>					
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Morton K. Sugar</b>				2. Date of Death Month <b>10</b> Day <b>12</b> Year <b>2000</b>		3. Time of Death <b>1435</b>			
4a. Facility Name (If not institution, give street and number) <b>University of Maryland Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>			
5. Social Security Number <b>216-32-6653</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEB. 18, 1918</b>			
9. Birthplace (State or Foreign Country) <b>MD</b>									
Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <b>1</b> Yes <b>2</b> No			
10e. Street and Number <b>33 STONEHENGE CIRCLE #1</b>				10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PROPRIETOR</b>		16b. Kind of Business/Industry <b>REAL ESTATE COMPANY</b>			
17. Father's Name (First, Middle, Last) <b>LOUIS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>KOSTINSKY MINNIE POSNER</b>					
19a. Informant's Name/Relationship (Type, Print) <b>HARRIETT SUGAR / WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>33 STONEHENGE CIRCLE #1 - BALTIMORE, MD 21208</b>					
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LIBERTY PARK SHAAREI ZION</b>		20c. Date <b>10/16/00</b>		20d. Location - City or Town, State <b>RANDALLSTOWN, MD</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Intracranial hemorrhage</b> Dua to (or as a consequence of):  <b>b.</b> Dua to (or as a consequence of):  <b>c.</b> Dua to (or as a consequence of):  <b>d.</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>pulmonary embolism</b>									
23b. Old tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown									
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No									
24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No									
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)					
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>			
				28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier 				29c. License number <b>P13988</b>		29d. Date signed (Month, Day, Year) <b>10/12/2000</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>UNIVERSITY OF MD HOSPITAL 22 S. GREENE ST. 21201</b>									
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>				32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32731

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PERRY SIEGEL</b>				2. Date of Death Month Day Year <b>OCTOBER 15, 2000</b>		3. Time of Death <b>8:40 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>GENESIS ELDERCARE RANDALLSTOWN</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>577-03-0021</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APR. 22, 1909</b>		
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number <b>2903 FALLSTAFF ROAD #308</b>		10f. Zip Code <b>21209</b>		
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MERCHANT</b>				16b. Kind of Business/Industry <b>RETAIL</b>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>MAX SIEGEL</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SARA FEINBERG</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>BERTHA SIEGEL / WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2903 FALLSTAFF ROAD #308 - BALTIMORE, MD 21209</b>				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ARLINGTON CHIZUK AMUNO</b>		20c. Location - City or Town, State <b>10/16/00 BALTIMORE, MD</b>		
	21. Signature of Funeral Service Licensee <i>Jay Alan Lewis</i>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>				
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. <b>ATHEROSCLEROTIC CARDIOVASCULARS</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death <b>YES</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEMENTIA</b> <b>CHRONIC LUNG DISEASE</b>							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred				
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>R. M. Zonies</i>				
To Be Completed by Physician/Medical Examiner	29c. License number <b>D20333</b>				29d. Date signed (Month, Day, Year) <b>10/16/00</b>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>R. M. ZONIES MD 1838 GARGENTREE RD PIKESVILLE MD 21208</b>				31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>				
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <i>James B. Sparks</i>				33. Date of Death (Month, Day, Year) <b>10/16/00</b>				
	34. Date of Death (Month, Day, Year) <b>10/16/00</b>				35. Date of Death (Month, Day, Year) <b>10/16/00</b>				

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32732

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia Maxine Taylor

2. Date of Death

October 11, 2000

3. Time of Death

11:00 am

4a. Facility Name (If not institution, give street and number)

Mariner Health of Glen Burnie

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

220-34-7001

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

1-1-21

9. Birthplace (State or Foreign Country)

Pa.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Sparks Glencoe

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2401 String Town Rd. Apt. G3

10f. Zip Code

21152

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10th

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Wesley Smith

18. Mother's Name (First, Middle, Maiden Surname)

Edith Unknown

19a. Informant's Name/Relationship (Type, Print)

James Taylor (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2401 String Town Rd. Apt. G3 Sparks Glencoe 21152

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Balto./Wash. Crem. 10-16

Date

10-16

20c. Location - City or Town, State

Laurel, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Charles Zeiler Funeral Home, Inc.

6224 Eastern Ave. Balto. MD. 21224

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. ATHENOSCUENOTIC CARDIOVASCULAR DYS

YES

Due to (or as a consequence of):

b. HYPERTENSION

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20333

29d. Date signed (Month, Day, Year)

10/12/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

K. ZOMIER MD 838 ALCONTOUR RD PARKERSBURG MD 21208

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 17 2000

32. Registrar's Signature

K. ZOMIER MD

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32733

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Johnnie Vaughn, Jr.</b>		2. Date of Death Month <b>October</b> Day <b>16</b> Year <b>2000</b>		3. Time of Death <b>11:50 AM.</b>	
4a. Facility Name (If not institution, give street and number) <b>Maryland General Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>NA</b>	
5. Social Security Number <b>238-70-2490</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>57</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>05-06-43</b>
9. Birthplace (State or Foreign Country) <b>NC</b>					
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>Prince George</b>	10c. City, Town or Location <b>Capital Heights</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>316 Possum Court</b>		10f. Zip Code <b>20735</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th Grade</b> College (1-4 or 5+) <b>NA</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Fencing worker</b>		16b. Kind of Business/Industry <b>company</b>			
17. Father's Name (First, Middle, Last) <b>Johnnie L. Vaughn, Sr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Ellen C. Powell</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Ellen M. Gaines</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20744 1004 Spring Valley Court Ft. Washington, MD</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Powell Family Cem. 10-21-2000 Conway, NC</b>		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>a. Aspiration Pneumonia</b> Due to (or as a consequence of): <b>b. Urinary Tract Infection</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>89371</b>		29d. Date signed (Month, Day, Year) <b>10/16/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Linda George, M.D. 40 Maryland General Hospital</b>					
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Johnnie Vaughn  
Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32734

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VIRGIL WHITE</b>				2. Date of Death Month <b>October</b> Day <b>14</b> Year <b>2000</b>				3. Time of Death <b>10:15 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Simi Hospital of Baltimore</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>249 18 7511</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>APR. 1, 1913</b>		9. Birthplace (State or Foreign Country) <b>SOUTH CAROLINA</b>		
	Usual Residence of Decedent										
10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10e. Street and Number <b>4800 SETON DRIVE</b>				10f. Zip Code <b>21215</b>				10g. Citizen of What Country? <b>U.S. OF A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b> College (14 or 5+) <b>UNKNOWN</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>RACE HORSE GROOM</b>				16b. Kind of Business/Industry <b>RACE TRACK</b>			
17. Father's Name (First, Middle, Last) <b>TOM WHITE</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>MINNIE BROWN</b>					
19a. Informant's Name/Relationship (Type and Name) <b>Lu Virgiline stevenson DAUGHTER</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7200 THIRD AVENUE APT. A101 SYKESVILLE, MD. 21784</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEMETERY</b>				20c. Location - City or Town, State <b>10/18/2000 BALTIMORE, MARYLAND</b>			
21. Signature of Funeral Service Licensee <b>Lewis T. Gwynn</b>					22. Name and Address of Facility <b>LEWIS T. GWYNN FUNERAL HOME 21215-6494 4517 PARK HEIGHTS AVENUE BALTO., MD.</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pneumonia</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dehydration</b> <b>Malnutrition</b> <b>Atrial fibrillation</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <b>Jonathan Hepler</b>				29c. License number <b>RES 000</b>				29d. Date signed (Month, Day, Year) <b>October 14, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jonathan Hepler 2401 W. Belvedere Baltimore, MD 21215</b>											
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature <b>B. Sparks</b>									

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32735

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kittie Irene Weller</b>						2. Date of Death Month Day Year <b>October 11 2000</b>		3. Time of Death <b>9:27 a.m.</b>										
	4a. Facility Name (If not institution, give street and number) <b>14527 Bain Road</b>						4b. City, Town, or Location of Death <b>Hancock</b>		4c. County of Death <b>Washington</b>										
Funeral Director	5. Social Security Number <b>214-32-4085</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 18, 1918</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>										
	Usual Residence of Decedent																		
10a. State <b>MD</b>		10b. County <b>Washington</b>		10c. City, Town or Location <b>Hancock</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
10e. Street and Number <b>14527 Bain Road</b>						10f. Zip Code <b>21750</b>		10g. Citizen of What Country? <b>U.S.A.</b>											
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>											
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>				16b. Kind of Business/Industry <b>Garment</b>											
17. Father's Name (First, Middle, Last) <b>Harry Younker</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Florence Miller</b>													
19a. Informant's Name/Relationship (Type, Print) <b>Roger E. Weller/Husband</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14527 Bain Road Hancock, MD 21750</b>													
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)						20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Stone Bridge Brethren Cemetery</b>		20c. Location - City or Town, State <b>Oct 13, 2000 Hancock, MD</b>											
21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility <b>Grove Funeral Home, P.A. 141 W. Main St. Hancock, MD 21750</b>													
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<table border="0"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a.</td> <td><b>renal failure</b></td> <td rowspan="4">                 Approximate Interval Between Onset and Death   <b>2 years</b>   <b>4 years</b> </td> </tr> <tr> <td>b.</td> <td><b>Multiple Myeloma</b></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>renal failure</b>	Approximate Interval Between Onset and Death  <b>2 years</b>  <b>4 years</b>	b.	<b>Multiple Myeloma</b>	c.		d.	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>renal failure</b>	Approximate Interval Between Onset and Death  <b>2 years</b>  <b>4 years</b>																
	b.	<b>Multiple Myeloma</b>																	
	c.																		
	d.																		
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No											
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred											
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier <i>[Signature]</i>						29c. License number <b>D46473</b>		29d. Date signed (Month, Day, Year) <b>10/13/00</b>											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Hind Hamdan MD 363 S. Cleveland Ave; Hagerstown, MD 21740</b>																			
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature <i>[Signature]</i>																	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

11/2

Handwritten signature or scribble



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32736

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HELEN ANNA WASHIEL</b>		2. Date of Death Month Day Year <b>OCT. 14, 2000</b>		3. Time of Death <b>6:10 pm</b>
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>212-34-8436</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>65</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>OCT. 16, 1934</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
Usual Residence of Decedent					
10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>102 S. WASHINGTON STREET</b>			10f. Zip Code <b>21231</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COURT CLERK</b>		16b. Kind of Business/Industry <b>MD. STATE GOVERNMENT</b>	
17. Father's Name (First, Middle, Last) <b>WALTER DYLEWSKI</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>MARGARET C. REESE</b>		
19a. Informant's Name/Relationship (Type, Print) <b>ROBERT WASHIEL/ HUSBAND</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>102 S. WASHINGTON STREET, BALTIMORE, MARYLAND 21231</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MEADOWRIDGE MEM. PARK 10/18/00</b>		20c. Location - City or Town, State <b>ELK RIDGE, MARYLAND</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>LILLY &amp; ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MARYLAND 21231</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. coronary artery disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. </b> Due to (or as a consequence of): <b>c. </b> Due to (or as a consequence of): <b>d. </b>					Approximate Interval Between Onset and Death <b>days</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>Diabetic mellitus</b>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28c. Describe how injury occurred		28d. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier MD		29c. License number <b>5-18151</b>		29d. Date signed (Month, Day, Year) <b>10-16-00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CHI-SHIANG CHEN, M.D. 301 ST. PAUL PLACE, SUITE 409, BALTIMORE, MARYLAND 21202</b>					
31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>		32. Registrar's Signature 			

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 32737

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frederick J. Wetzel, Sr.</b>				2. Date of Death Month <b>October</b> Day <b>14</b> , Year <b>2000</b>				3. Time of Death <b>9:20</b>			
	4a. Facility Name (If not institution, give street and number) <b>1409 Gordon Drive</b>				4b. City, Town, or Location of Death <b>Glen Burnie</b>				4c. County of Death <b>Anne Arundel</b>			
Funeral Director	5. Social Security Number <b>212-28-7814</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>3/4/1926</b>		9. Birthplace (State or Foreign Country) <b>MD</b>			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Glen Burnie</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>1409 Gordon Drive</b>				10f. Zip Code <b>21061</b>		10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Steel Worker</b>			16b. Kind of Business/Industry <b>Kaiser Aluminum</b>				
	17. Father's Name (First, Middle, Last) <b>Norman H. Wetzel</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rosalia Hardagen</b>							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Patricia Freed - Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>806 Paradise Lane, Glen Burnie, MD 21061</b>							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cem.</b>		Date <b>10/18</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>			
	21. Signature of Funeral Service Licensee  <b>Kelly Gregory Hink</b>				22. Name and Address of Facility <b>FINK FUNERAL HOME, PA</b> <b>426 Crain Hwy., SW, Glen Burnie, MD 21061</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <b>CARDIO RESPIRATORY ARREST</b> Due to (or as a consequence of): b. <b>METASTATIC ADENOCARCINOMA OF THE LIVER 2 YEARS</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <b>1 DAYS</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CAROTID ARTERY DISEASE. DEPTIC</b> <b>ULCER DISEASE</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier  <b>MD</b>		29c. License number <b>D52488</b>		29d. Date signed (Month, Day, Year) <b>16th October 2000</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAMASWAMY I. RANGARAJAN 7445 FURNACE BRANCH RD GLENBURNIE MD 21060.</b>												
31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature 										

ORIGINAL

W. D. Jones

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32738

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES EVERETT WHALEN SR.

2. Date of Death

Month Day Year  
October 12 2000

3. Time of Death

2120

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

FT. WASHINGTON

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

216-74-5399

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 4 1958

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

FORESTVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3503 FORREST EDGE RD SOUTH

10f. Zip Code

20747

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

SKILLED LABORER

16b. Kind of Business/Industry

ASPHALT PAVING

17. Father's Name (First, Middle, Last)

HENRY A. WHALEN SR.

18. Mother's Name (First, Middle, Maiden Surname)

CARRIE A. JORDAN

19a. Informant's Name/Relationship (Type, Print)

Hilda M. Whalen/ Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3503 Forrest Edge Rd. S., Forestville, Md. 20747

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial Park

Date

10-19-00 BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WILLIAM C BROWN COMMUNITY FUNERAL HOME PA

1206 W NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Acute Respiratory Failure* *unknown*

Due to (or as a consequence of):

b. *lung cancer* *unknown*

Due to (or as a consequence of):

c. *pneumonia* *unknown*

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

15. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARASTOO Yazdani 11418 Livingston Rd Ft Washington, m

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 17 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit form.

Division of Vital Records, P.O. Box 68760,







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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32739

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Daniel Ashley Youngbar Sr.</b>				2. Date of Death Month Day Year <b>October 10 2000</b>		3. Time of Death <b>1:57 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>5233 Kramme Avenue</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>215 64 4303</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>44</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 19, 1955</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Baltimore</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>5233 Kramme Avenue</b>		10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>U.S.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1977-1983</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>		16b. Kind of Business/Industry <b>Concrete Company</b>					
17. Father's Name (First, Middle, Last) <b>Michael J. Youngbar Sr.</b>		18. Mother's Name (First, Middle, Maiden Summa) <b>Delores A. Akers</b>		19a. Informant's Name/Relationship (Type, Print) <b>Daniel Youngbar Jr. / Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5233 Kramme Avenue Baltimore, Maryland 21225</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Memorial Park</b>		20c. Date <b>10/14/00</b>		20d. Location - City or Town, State <b>Glen Burnie, Maryland</b>			
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>		23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>EPIDURAL MASS, large a. SPINAL CORD COMPRESSION T2-S1 Due to (or as a consequence of): b. MULTIPLE MYELOMA (post stem cell transplant) Due to (or as a consequence of): c. Renal failure Due to (or as a consequence of): d. DIABETES, INSULIN dependent (insulin) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b>		Approximate Interval Between Onset and Death <b>2mo 20mo 4mo 1yr.</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>10/10/00</b>		28b. Time of Injury <b>M</b>	
28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Michael L. Levin MD</b>		29c. License number <b>D-06085</b>		29d. Date signed (Month, Day, Year) <b>OCT 10, 2000</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MICHAEL L. LEVIN MD</b>		31. Date filed (Month, Day, Year) <b>OCT 17 2000</b>		32. Registrar's Signature <i>[Signature]</i>		33. Date of Death (Month, Day, Year) <b>OCT 10, 2000</b>		34. Time of Death <b>1:57 PM</b>	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32740

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JANICE G. ANDREWS</b>					2. Date of Death Month Day Year <b>SEPT. 29, 2000</b>		3. Time of Death <b>0315</b>		
	4a. Facility Name (If not institution, give street and number) <b>TALBOT HOSPICE HOUSE</b>					4b. City, Town, or Location of Death <b>EASTON</b>		4c. County of Death <b>TALBOT</b>		
Funeral Director	5. Social Security Number <b>218-34-3322</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b>		8. Date of Birth (Month, Day, Year) <b>JAN. 21, 1938</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>TALBOT</b>		10c. City, Town or Location <b>CORDOVA</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>10708 CHAPEL ROAD</b>				10f. Zip Code <b>21625</b>			10g. Citizen of What Country? <b>USA</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4or 5+) <b>-0-</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>REFRESHMENT MANAGER</b>			16b. Kind of Business/Industry <b>FRATERNAL ORGANIZATION</b>			
17. Father's Name (First, Middle, Last) <b>CLIFFORD M. GEORGE</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>MARIE PINDER</b>					
19a. Informant's Name/Relationship (Type, Print) <b>ROBERT E. ANDREWS / HUSBAND</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10708 CHAPEL ROAD, CORDOVA, MD 21625</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>FAIRVIEW CHURCH CEMETERY</b>			20c. Date <b>10-02-2000</b>		20d. Location - City or Town, State <b>CORDOVA, MD</b>		
21. Signature of Funeral Service Licensee <i>M. F. Newnam</i> <b>CFSP</b>					22. Name and Address of Facility <b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <i>Colon Carcinoma</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death <b>3 1/2 yrs</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			28. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <b>HOSPICE HOUSE</b>							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and Title of certifier <i>[Signature]</i>			29c. License number <b>D39887</b>		29d. Date signed (Month, Day, Year) <b>9/29/00</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DAVID H. SMITH, M.D., 29486 PINTAIL DRIVE, EASTON, MD 21601</b>										
31. Date filed (Month, Day, Year) <b>OCT 02 2000</b>			32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32741

Amend #26, 10/3/2000, BMW, Montg. Co.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES MATOKA ALTEMUS

2. Date of Death

Month Day Year  
OCTOBER 1, 2000

3. Time of Death

0930

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

12224 GALESVILLE ROAD

4b. City, Town, or Location of Death

GAITHERSBURG

4c. County of Death

MONTGOMERY

5. Social Security Number

118-14-0693

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG. 9, 1919

9. Birthplace (State or Foreign Country)

S. CAROLINA

Usual Residence of Decedent

10a. State

D.C.

10b. County

NONE

10c. City, Town or Location

WASHINGTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1439 CHANNING ST. N.E.

10f. Zip Code

20018

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NURSE

16b. Kind of Business/Industry

NURSING

17. Father's Name (First, Middle, Last)

JAMES

McKINNEY

18. Mother's Name (First, Middle, Maiden Surname)

MATOKA

McGRIFF

19a. Informant's Name/Relationship (Type, Print)

AVE SLOANE/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12224 GALESVILLE DR., GAITHERSBURG, MD. 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

10/9/00

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

W. W. Chambers

22. Name and Address of Facility

M00091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

METASTATIC CARCINOMA

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) Daughter's Home

27. Manner of Death

1 ☒ Natural 2 ☐ Accidental 3 ☐ Suicidal 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W. W. Chambers

29c. License number

015236

29d. Date signed (Month, Day, Year)

OCTOBER 1 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHIEF Z. MARSHALL, MD. (OMB) 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 03 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32742

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edna J. Anderson				2. Date of Death Month Day Year October 4, 2000				3. Time of Death 1:15pm	
	4a. Facility Name (If not institution, give street and number) Wilson Health Care				4b. City, Town, or Location of Death Gaithersburg				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 201-09-5716		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) June 22, 1919		9. Birthplace (State or Foreign Country) North Carolina	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Md.		10b. County Montgomery		10c. City, Town or Location Gaithersburg				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 401 Russell Ave #309				10f. Zip Code 20877		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
	17. Father's Name (First, Middle, Last) James Holler				18. Mother's Name (First, Middle, Maiden Surname) Sara Smith					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Carol Laser (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11224 Valley Bend Dr. Germantown, Md. 20876					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date Oct. 5, 2000		20c. Location - City or Town, State Alexandria, Va.	
	21. Signature of Funeral Service Licensee Curtis E. Day				22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, Md. 20877					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. cerebrovascular accident Due to (or as a consequence of): b. atrial fibrillation Due to (or as a consequence of): c. coronary artery disease Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death 1 week years years									
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier Steven Dolinsky MD				29c. License number 20148		29d. Date signed (Month, Day, Year) Oct 4, 2000			
	30. Name and address of person who completed cause of death (file 23a) (Type, Print) Steven Dolinsky - 911 Russell Ave, Gaithersburg, Md.									
State Registrar	31. Date filed (Month, Day, Year) OCT 06 2000				32. Registrar's Signature B. Sparks					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Laura Lynn Arnold

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32743

amend item 23a, 27 per me G789 11/13/00 yf

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LAURA LYNN ARNOLD				2. Date of Death Month Day Year October 12, 2000				3. Time of Death 7:05 A.M.		
	4a. Facility Name (If not institution, give street and number) 2062 Stratton Court				4b. City, Town, or Location of Death Bel Air				4c. County of Death Harford		
Funeral Director	5. Social Security Number 220-82-9800		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 38 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 9, 1961		9. Birthplace (State or Foreign Country) Maryland		
	10a. State Maryland				10b. County Harford		10c. City, Town or Location Bel Air				
10e. Street and Number 2062 Stratton Court				10f. Zip Code 21015				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Loan Officer/Processor				16b. Kind of Business/Industry Mortgage Company			
17. Father's Name (First, Middle, Last) Frank B. Oechsler				18. Mother's Name (First, Middle, Maiden Surname) Sylvia Ulrich							
19a. Informant's Name/Relationship (Type, Print) Jesse J. Arnold (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2062 Stratton Court, Bel Air, MD 21015							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment				20b. Place of Disposition (Name of cemetery, crematory or other place) Highview Memorial Gardens				20c. Location - City or Town, State Fallston, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD 21014							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No											24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier 				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) October 13, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodor M. McKing 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) OCT 17 2000				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32744

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ERNEST CARROLL BLANKENSHIP</b>				2. Date of Death Month <b>10</b> Day <b>1</b> Year <b>2000</b>		3. Time of Death <b>9:30 AM</b>		
	4e. Facility Name (If not institution, give street and number) <b>74 Ocean Parkway</b>				4b. City, Town, or Location of Death <b>Ocean Pines</b>		4c. County of Death <b>Worcester</b>		
Funeral Director	5. Social Security Number <b>218-36-2793</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>9/10/1938</b>		
	10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Ocean Pines</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Korean</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Production Control Manager</b>		16b. Kind of Business/Industry <b>Defense</b>			
17. Father's Name (First, Middle, Last) <b>Charles Ray Blankenship</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Maretta Emrich</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Maretta Hoffman/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>65 Birdnest Dr. Berlin, MD 21811</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cape Henlopen Crematory</b>		20c. Location - City or Town, State <b>10/2/00 Frankford, DE</b>			
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Burbage Funeral Home</b> <b>108 William st. Berlin, MD 21811</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Lung Cancer with metastasis to Brain + Liver</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>a. b. c. d.</b>				Approximate Interval Between Onset and Death <b>3128100</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b> <b>Coronary Artery Disease</b> <b>Hypertension</b>				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>H0056186</b>	
29d. Data signed (Month, Day, Year) <b>10/2/00</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Scott Sulman P.O. 11107 Racetrack Rd Berlin, Md 21811</b>					
31. Date filed (Month, Day, Year) <b>OCT 09 2000</b>				32. Registrar's Signature <i>[Signature]</i>					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32745

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JONIBEL TRELEASE BLAIR</b>				2. Date of Death Month Day Year <b>Sept. 30 2000</b>				3. Time of Death <b>0016</b>	
	4a. Facility Name (If not institution, give street and number) <b>Memorial Hospital Easton</b>				4b. City, Town, or Location of Death <b>Easton</b>				4c. County of Death <b>Talbot</b>	
Funeral Director	5. Social Security Number <b>538-14-0716</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>JULY 14, 1910</b>		9. Birthplace (State or Foreign Country) <b>MISSOURI</b>		10a. State <b>MD</b>		10b. County <b>TALBOT</b>		10c. City, Town or Location <b>EASTON</b>	
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>501 DUTCHMAN'S LANE</b>		10f. Zip Code <b>21601</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SOCIAL WORKER</b>		16b. Kind of Business/Industry <b>STATE GOVERNMENT</b>		17. Father's Name (First, Middle, Last) <b>FRANK TRELEASE</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>SADIE MAI CORNELIUS</b>		19a. Informant's Name/Relationship (Type, Print) <b>DONALD D. BLAIR, SR./SON</b>		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>531 SOUTH WASHINGTON STREET, EASTON, MD 21601</b>		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHESAPEAKE CREMATION CTR.</b>		20c. Date <b>10/2/2000</b>		20d. Location - City or Town, State <b>CHESTER, MD</b>		
21. Signature of Funeral Service Licensed <i>[Signature]</i>		22. Name and Address of Facility <b>FELLOWS, HELFENBEIN, &amp; NEWNAM FUNERAL HOME, 200 S. HARRISON STREET, EASTON, MD 21601</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>urosepsis</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>myocardia infarction</b> <b>pulmonary fibrosis</b>		Approximate Interval Between Onset and Death <b>3 days</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i> <b>HOROU LAURA JIN</b>		29c. License number <b>D0055484</b>		29d. Date signed (Month, Day, Year) <b>9-30-2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>H. LAURA JIN, M.D., 219 S. WASHINGTON STREET, EASTON, MD 21601</b>		31. Date filed (Month, Day, Year) <b>OCT 03 2000</b>		32. Registrar's Signature <i>[Signature]</i> <b>B. Sparks</b>		33. Date of Death <b>Sept. 30 2000</b>		34. Time of Death <b>0016</b>		



jhm  
PAMELA JEANNE  
BENSON

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State of Maryland / Department of Health and Mental Hygiene

00 32746

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PAMELA JEAN BENSON		2. Date of Death Month Day Year OCTOBER 04, 2000		3. Time of Death 22:39 PM
	4a. Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER		4b. City, Town, or Location of Death CHEVERLY		4c. County of Death PRINCE GEORGES
Funeral Director	5. Social Security Number 228-90-7991	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 43 Yrs.	8. Date of Birth (Month, Day, Year) JULY 22, 1957	9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MD	10b. County CALVERT	10c. City, Town or Location DUNKIRK		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number 9912 MCINTOSH DRIVE		10f. Zip Code 20754		10g. Citizen of What Country? USA
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: WHITE		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) BARTENDER
	16b. Kind of Business/Industry FOOD SERVICE		17. Father's Name (First, Middle, Last) DAVID G. BENSON, JR.		18. Mother's Name (First, Middle, Maiden Surname) PHYLLIS MARIE COBER
	19a. Informant's Name/Relationship (Type, Print) DAVID G. BENSON, III		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9912 MCINTOSH DRIVE, DUNKIRK, MD 20754		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) FAIRVIEW CHURCH CEMETERY		20c. Location - City or Town, State 10-8-2000 CORDOVA, MD
	21. Signature of Funeral Service Licensee Joseph M. Ostrowski		22. Name and Address of Facility 200 S. HARRISON ST EASTON, MD 21601 FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple injuries Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		Approximate Interval Between Onset and Death
	23c. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		23d. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
24. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
26. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		27a. Date of Injury (Month, Day, Year) 1/10/04		27b. Time of Injury 2:38 PM	
27c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		27d. Describe how injury occurred Subject pedestrian struck by vehicle		27e. Location (Street and Number or Rural Route Number, City or Town, State) Route 260 near Route 4 Owings Maryland	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) roadway		28b. Date of Death OCTOBER 04, 2000		28c. Time of Death 22:39 PM	
29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Theodore M. King, MD		29c. License number OCME	
29d. Date signed (Month, Day, Year) OCTOBER 05, 2000		29f. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore M. King 111 Penn Street, Baltimore, Maryland 21201			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Theodore M. King 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) OCT 06 2000		32. Registrar's Signature B. Sparks	

Baltimore, Maryland 21215-0020

Permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32747

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHARLES WILLIAM BAECHLER			2. Date of Death Month Day Year SEPT. 28. 2000			3. Time of Death 9:25AM					
	4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL			4b. City, Town, or Location of Death ROCKVILLE			4c. County of Death MONTGOMERY					
Funeral Director	5. Social Security Number 144-09-0528		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) OCT. 3, 1919		9. Birthplace (State or Foreign Country) PENNSYLVANIA			
	Usual Residence of Decedent			10a. State MARYLAND			10b. County MONTGOMERY			10c. City, Town or Location ROCKVILLE		
To Be Completed by Funeral Director	10e. Street and Number 14632 BAUER DRIVE APT. #7			10f. Zip Code 20853-2456			10g. Citizen of What Country? UNITED STATES			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1939-44			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ENGINEER			16b. Kind of Business/Industry US POSTAL SERVICE					
	17. Father's Name (First, Middle, Last) CHARLES W. BAECHLER, SR.			18. Mother's Name (First, Middle, Maiden Surname) ANNA K. LIVVERT								
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) JEFFREY C. BAECHLER/SON			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11100 LADY ALLISON LANE MIDLOTHIAN, VA 23113-1422								
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) FT. LINCOLN CREMATORY			20c. Location - City or Town, State 09/30/00 BRENTWOOD, MD					
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVE. SILVER SPRING, MD 20904								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. METASTATIC PROSTATE CANCER Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 5 YEARS					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			28d. Describe how injury occurred					
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number D32407			29d. Date signed (Month, Day, Year) September 28, 2000		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH M. HAGGERTY MD 9707 MEDICAL CTR DRIVE ROCKVILLE, MD 20850											
State Registrar	31. Date filed (Month, Day, Year) OCT 02 2000			32. Registrar's Signature 								

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32748

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MELVIN R. BANKS

2. Date of Death

Month Day Year  
SEPT 30, 2000

3. Time of Death

3:15 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

CASEY HOUSE

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

148-05-9923

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
09-03-1918

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15115 INTERLACHEN DRIVE #818

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

AGRICULTURAL STATICIAN

16b. Kind of Business/Industry

U.S.D.A.

17. Father's Name (First, Middle, Last)

ABRAHAM BANKS

18. Mother's Name (First, Middle, Maiden Surname)

EDITH WISOTSKY

19a. Informant's Name/Relationship (Type, Print)

FLORENCE BANKS/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15115 INTERLACHEN DR #818, SILVER SPRING, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

JUDEAN MEMORIAL GARDENS

Date

OCT 3, 2000

20c. Location - City or Town, State

OLNEY, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. NON-HODGKINS LYMPHOMA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D15046

29d. Date signed (Month, Day, Year)

October 1, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEPHEN NEWMAN, MD 6001 MUNCASTER MILL ROAD, ROCKVILLE, MARYLAND 20850

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 04 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12



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State of Maryland / Department of Health and Mental Hygiene

00 32749

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lois M. Beckett</b>				2. Date of Death Month Day Year <b>October 1, 2000</b>		3. Time of Death <b>1:00 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Bedford Court Nursing Home</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>568-24-7766</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>91</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 4, 1909</b>		9. Birthplace (State or Foreign Country) <b>Kansas</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Temple Hills</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>5206 Springwood Drive</b>				10f. Zip Code <b>20748</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Federal Government</b>		
17. Father's Name (First, Middle, Last) <b>Charles C. Beckett</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>B. Estelle Warren</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Virginia B. Chichester/Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5206 Springwood Drive, Temple Hills, Maryland 20748</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MONTGOMERY CREMATORIUM INC.</b>		Date <b>OCTOBER 3, 2000</b>		20c. Location - City or Town, State <b>BETHESDA, MARYLAND</b>		
21. Signature of Funeral Service Licensee  <b>M00335</b>				22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>4 Years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Severe Alzheimer's Disease</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  <b>James A. Rossi M.D.</b>				29c. License number <b>D 24543</b>		29d. Date signed (Month, Day, Year) <b>October 2, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James A. Rossi, M.D. 3305 North Leisure World Boulevard Silver Spring, Maryland 20906</b>								
31. Date filed (Month, Day, Year) <b>OCT 04 2000</b>		32. Registrar's Signature 						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32750

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Zoltan Berkovits				2. Date of Death Month Day Year September 28, 2000				3. Time of Death 7:30pm	
	4a. Facility Name (If not Institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 126-74-9354		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) January 17, 1914		9. Birthplace (State or Foreign Country) Romania		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 14510 Homecrest Road #2019		10f. Zip Code 20906		10g. Citizen of What Country? United States		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Manager	
	16b. Kind of Business/Industry Retail		17. Father's Name (First, Middle, Last) Martin Berkovits		18. Mother's Name (First, Middle, Maiden Surname) Berta Landesman		19a. Informant's Name/Relationship (Type, Print) Magda Berkovits / Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14510 Homecrest Road #2019, Silver Spring, MD 20906	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesed Shel Emmes		20c. Location - City or Town, State Washington, DC		21. Signature of Funeral Service Licensee		22. Name and Address of Facility Danzansky Goldberg Memorial Chapel, Inc 1170 Rockville Pike, Rockville, MD 20852	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. AMYOTROPIC LATERAL SCLEROSIS Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Approximate Interval Between Onset and Death Years	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier		29c. License number D38457		29d. Date signed (Month, Day, Year) SEPTEMBER 29, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N-GUYAL MIA, 3801 INTERNATIONAL DR #211, S. SPRING, MD 20906		31. Date filed (Month, Day, Year) OCT 04 2000	
	32. Registrar's Signature B. Sparks									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

00 32751

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Harmon Blake				2. Date of Death Month Day Year September 29, 2000				3. Time of Death 6:46 AM		
	4a. Facility Name (If not institution, give street and number) 15307 Frederick Road				4b. City, Town, or Location of Death Woodbine				4c. County of Death Howard		
Funeral Director	5. Social Security Number 113-09-0562		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) February 6, 1917		9. Birthplace (State or Foreign Country) New York		10a. State Maryland		10b. County Howard		10c. City, Town or Location Woodbine		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 15307 Frederick Road		10f. Zip Code 21797		10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Receptionist	
16b. Kind of Business/Industry Funeral Home		17. Father's Name (First, Middle, Last) Joseph Harmon		18. Mother's Name (First, Middle, Maiden Surname) Selma Kaufold		19a. Informant's Name/Relationship (Type, Print) Kathleen B. Curry/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15307 Frederick Road, Woodbine, Maryland 21797			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. 2, 2000		Date October		20c. Location - City or Town, State Bethesda, Maryland		21. Signature of Funeral Service Licensee M00672		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Gastrointestinal Bleeding Due to (or as a consequence of): b. Cardiorespiratory Arrest Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death 1 Month		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Isabelle	
29c. License number D45014		29d. Date signed (Month, Day, Year) October 2, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Isabella Martire, M.D., 8379 Cherry Lane, Laurel, Maryland 20707-4831		31. Date filed (Month, Day, Year) OCT 03 2000		32. Registrar's Signature B. Sparks			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32752

amend item 23a,b,27 per me G788 10/18/00 yf

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SEAN DAVID BURKE</b>				2. Date of Death Month Day Year <b>OCTOBER 03, 2000</b>				3. Time of Death <b>3:16 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				4b. City, Town, or Location of Death <b>SILVER SPRING</b>				4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>294-84-1406</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>14</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>July 20, 1986</b>		9. Birthplace (State or Foreign Country) <b>Ohio</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Burtonsville</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>4260 Dunwood Terrace</b>		10f. Zip Code <b>20866</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+) <b>College</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>		16b. Kind of Business/Industry <b>High School</b>		17. Father's Name (First, Middle, Last) <b>John J. Burke</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lynn L. Dugas</b>		19e. Informant's Name/Relationship (Type, Print) <b>Lynn L. Burke / Mother</b>		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4260 Dunwood Terrace, Burtonsville, MD 20866</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. Location - City or Town, State <b>10/7/00 Alexandria, VA</b>		21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>CARDIAC ARRHYTHMIA</b> Due to (or as a consequence of):  b. <b>HYPERTROPHIC CARDIOMYOPATHY</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24e. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury M</b> <b>28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</b>		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		
29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>OCTOBER 04, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis Chute</b>		31. Date filed (Month, Day, Year) <b>OCT 06 2000</b>		32. Registrar's Signature 		
31. Date filed (Month, Day, Year) <b>OCT 06 2000</b>		32. Registrar's Signature 		31. Date filed (Month, Day, Year) <b>OCT 06 2000</b>		32. Registrar's Signature 		31. Date filed (Month, Day, Year) <b>OCT 06 2000</b>		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32753

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) EDGAR AUSTIN BAKER SR  
2. Date of Death Month Day Year October 1 2000  
3. Time of Death 6:15 p.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number) Wicomico Nursing Home  
4b. City, Town, or Location of Death Salisbury  
4c. County of Death Wicomico  
5. Social Security Number 222-16-0131  
6. Sex ☒ M ☐ F  
7. Age (In yrs. last birthday) 74 Yrs.  
8. Date of Birth (Month, Day, Year) June 20, 1926  
9. Birthplace (State or Foreign Country) Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent  
10a. State Maryland  
10b. County Wicomico  
10c. City, Town or Location Salisbury  
10d. Inside City Limits ☐ Yes ☒ No  
10e. Street and Number 1615 South Kaywood Drive  
10f. Zip Code 21804  
10g. Citizen of What Country? USA  
11. Marital Status ☐ Never Married ☐ Married ☐ Widowed ☒ Divorced  
12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes ☐ No If Yes, Give Year or Dates AirForce  
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify:  
14. Race - American Indian, Black, White, etc. Specify: White  
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Reporter  
16b. Kind of Business/Industry Court  
17. Father's Name (First, Middle, Last) Edgar Benjamin Baker  
18. Mother's Name (First, Middle, Maiden Surname) Mary Jane Dorey  
19a. Informant's Name/Relationship (Type, Print) Edgar A. Baker Jr/Son  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1615 S. Kaywood Dr., Salisbury, MD 21804  
20a. Method of Disposition ☐ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☒ Other (Specify) Entombment  
20b. Place of Disposition (Name of cemetery, crematory or other place) Springhill Memory Gardens  
20c. Location - City or Town, State Hebron, MD  
20d. Date 10/5/00  
21. Signature of Funeral Service Licensee David H. Thompson  
22. Name and Address of Facility Holloway Funeral Home Professional Association  
501 Snow Hill Rd., Salisbury, MD 21804

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
Immediate Cause (Final disease or condition resulting in death) a. Carcinoma, lung, left lower lobe 2 yrs  
Due to (or as a consequence of):  
b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):  
Approximate Interval Between Onset and Death

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  
Chronic Obstructive Pulmonary Disease  
Essential Hypertension, Hypertensive  
Heart Disease, Multi-Infarct Dementia  
23b. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown  
24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No  
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No  
Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA  
Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)  
26. Place of Death (Check only one)  
27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined  
28a. Date of Injury (Month, Day, Year)  
28b. Time of Injury M  
28c. Injury at Work? ☐ Yes ☐ No  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Gregorio M. Belloso MD  
29c. License number D-29505  
29d. Date signed (Month, Day, Year) 10-2-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregorio Belloso 5302 Chinaberry Drive Salisbury MD 21801

State  
Registrar

31. Date filed (Month, Day, Year) OCT 04 2000  
32. Registrar's Signature B. Sparks

ORIGINAL

Edgar Baker  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

JMB  
1/1A





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32754

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PATRICIA GREENE BERRY

2. Date of Death

Month Day Year  
Sept 28 2000

3. Time of Death

8:15 AM

4a. Facility Name (If not institution, give street and number)

Genesis ElderCare - The Pines

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

226-58-8785

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
11/19/42

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

613 SHERWOOD CIRCLE

10f. Zip Code

21804

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

SAMUEL GREENE

18. Mother's Name (First, Middle, Maiden Surname)

DELLA MARSHALL

19a. Informant's Name/Relationship (Type, Print)

MILLARD FILLMORE BERRY, JR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

613 SHERWOOD CIRCLE, SALISBURY, MARYLAND 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKSLEY CEMETERY

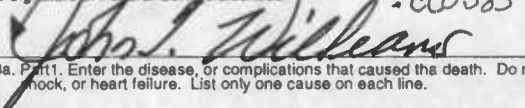
Date

9/30/00

20c. Location - City or Town, State

PARKSLEY, VIRGINIA

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

WILLIAMS-PARKSLEY FUNERAL HOME  
25046 PARKSLEY RD., PARKSLEY, VIRGINIA 23421

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. malignant neoplasm brain  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

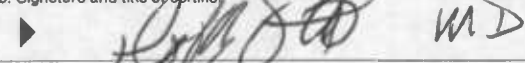
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 MD

29c. License number

D25750

29d. Date signed (Month, Day, Year)

9/28/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT SANCHEZ, MD 508 INDIAN AVENUE EASTON, MD 21601

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 02 2000

32. Registrar's Signature

Patricia Berry  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

John Williams

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32755

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn Blackburn

2. Date of Death

Month Day Year  
10 - 1 - 2000

3. Time of Death

20:52

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

214-14-2878

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 30, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6104 Twin Point Cove Rd.

10f. Zip Code

21613

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Vice President

16b. Kind of Business/Industry

Drapery

17. Father's Name (First, Middle, Last)

Henry Seabrease

18. Mother's Name (First, Middle, Maiden Surname)

Sophie Miller

19a. Informant's Name/Relationship (Type, Print)

Spouse  
Ellsworth Carlyle Blackburn

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6104 Twin Point Cove Rd., Cambridge, MD 21613

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cambridge Crematory

Date

10-07

20c. Location - City or Town, State

Cambridge, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Curran-Bromwell Funeral Home, P.A.

308 High St., Cambridge, MD 21613

23a. (Part I) Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

25min.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

Years

c. Tobacco abuse

Due to (or as a consequence of):

Years

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

H51793

29d. Date signed (Month, Day, Year)

10/2/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugene Newman D.O. 503 Byrn St. Cambridge MD 21613

31. Date filed (Month, Day, Year)

OCT 04 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Blackburn, Evelyn S.

*[Faint, illegible text covering the page, possibly bleed-through from the reverse side.]*

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32756

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ADDIE M. BAKER

2. Date of Death

Month

Day

Year

SEPTEMBER 29, 2000

3. Time of Death

0615

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

222-44-3341

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

9/23/1906

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

DELAWARE

10b. County

SUSSEX

10c. City, Town or Location

FRANKFORD

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

RT. 3 BOX 198

10f. Zip Code

19945

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOMMAKING

17. Father's Name (First, Middle, Last)

SAM BAKER

18. Mother's Name (First, Middle, Maiden Surname)

MELISSA BOWDEN

19a. Informant's Name/Relationship (Type, Print)

LINDA J. DAVIS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RT. 3 BOX 205G, FRANKFORD, DE 19945

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MILLSBORO CEMETERY

Date

10/4/00

20c. Location - City or Town, State

MILLSBORO, DE

21. Signature of Funeral Service Licensee

Richard T. Watson

22. Name and Address of Facility

WATSON FUNERAL HOME, MILLSBORO, DE 19966

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pneumonia

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2-40

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypoxemia

Congestive Heart failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert A. G. So

29c. License number

H0056197

29d. Date signed (Month, Day, Year)

9/29/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 E. Carroll St Salisbury MD 21801; Robert Coker, M.D.

31. Date filed (Month, Day, Year)

OCT 02 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

ORIGINAL

A-001E BAKER

222-44-3341

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32757

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>TIMOTHY MICHAEL CROKER</b>				2. Date of Death Month Day Year <b>October 03, 2000</b>		3. Time of Death <b>3:43 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>West Bound Route 50 near Whitehall Road</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>217-21-1159</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>20</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 7, 1979</b>	9. Birthplace (State or Foreign Country) <b>MD</b>	
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Berlin</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>1282 Ocean Parkway</b>				10f. Zip Code <b>21811</b>		10g. Citizen of What Country? <b>US</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner-Manager</b>		16b. Kind of Business/Industry <b>Water Sports</b>		
17. Father's Name (First, Middle, Last) <b>Ronald Croker</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sheila Marie McHugh</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Ronald Croker</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1282 Ocean Parkway, Berlin, Md. 21811</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cape Henlopen Crematory 10-4-00 Frankford, Delaware</b>		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>The Burbage Funeral Home 108 William St., Berlin, Md. 21811</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Multiple Injuries</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>				
27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>10/3/00</b>		28b. Time of Injury <b>3:40 A M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred <b>Driver involved in motor vehicle accident</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Rt. 50 Westbury Annapolis, MD</b>		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>October 03, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JACK M. TINS, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>OCT 05 2000</b>				32. Registrar's Signature <i>[Signature]</i>				

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32758

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Louis Martin Caspar				2. Date of Death Month Day Year October 5, 2000		3. Time of Death 5:29 AM	
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital				4b. City, Town, or Location of Death Leonardtown		4c. County of Death St. Mary's	
Funeral Director	5. Social Security Number 578-22-6816		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 76 Yrs.		8. Date of Birth (Month, Day, Year) 11-26-1923	
	9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Charles		10c. City, Town or Location Indian Head	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 23 Elder Place		10f. Zip Code 20640		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Postal Worker		16b. Kind of Business/Industry United States Government			
	17. Father's Name (First, Middle, Last) George M. Caspar				18. Mother's Name (First, Middle, Maiden Surname) Marie Howard			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Shirley May Caspar/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Elder Place, Indian Head, Maryland 20640			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cemetery		Date 10-10-2000		20c. Location - City or Town, State Cheltenham, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee  M00668				22. Name and Address of Facility Williams Funeral Home, P.A. 20640 4270 Hawthorne Road, Indian Head, Maryland			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cardiorespiratory arrest</u> Due to (or as a consequence of): b. <u>Cerebrovascular accident</u> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death 15 MINS 2 DAYS	
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes mellitus</u> <u>Hepatic encephalopathy</u> <u>Seizure disorder</u>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier  MD				29c. License number D0044916		29d. Date signed (Month, Day, Year) 10/05/2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TERRANCE A. COLLINS, MD 23511 HOLLYWOOD RD. P.O. Box 2101 LEONARDTOWN, MD. 20650							
State Registrar	31. Date filed (Month, Day, Year) OCT 06 2000				32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

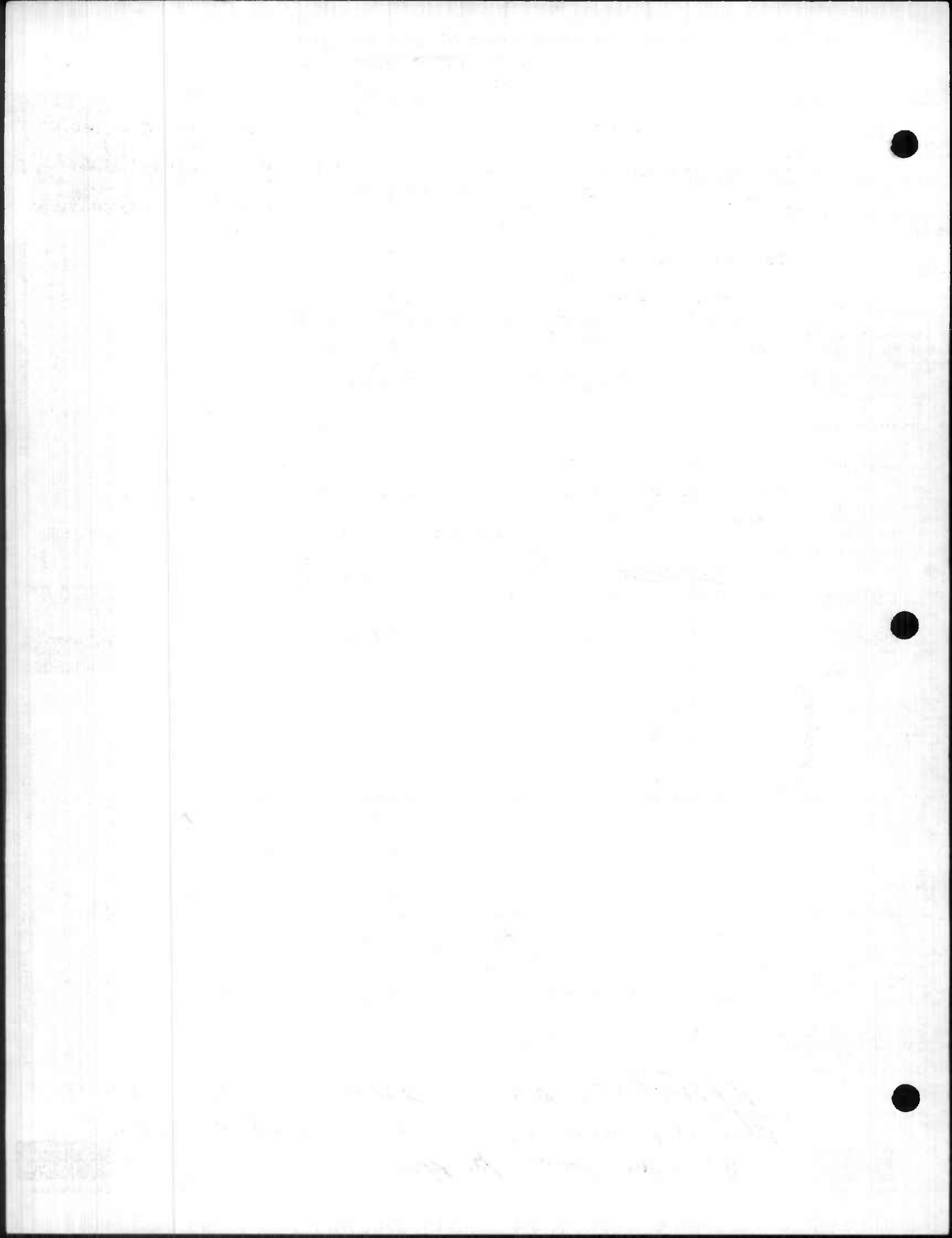
State of Maryland / Department of Health and Mental Hygiene

00 32759

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Carrie Camper				2. Date of Death Month Day Year September 26 2000				3. Time of Death 2130	
	4a. Facility Name (If not institution, give street and number) Dorchester General Hospital				4b. City, Town, or Location of Death Cambridge				4c. County of Death Dorchester	
Funeral Director	5. Social Security Number 220-01-2468		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 93 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 9, 1907		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Dorchester		10c. City, Town or Location Hurlock				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 4706 Skeet Club Road				10f. Zip Code 21643		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 3 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Packer				16b. Kind of Business/Industry Harper and Batemans			
	17. Father's Name (First, Middle, Last) Edward Parker				18. Mother's Name (First, Middle, Maiden Surname) Ethel Baltimore					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Alberta Thomas / Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1217 Springwood Ct., Arnold, Maryland 21012					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Thomason town Cemetery		20c. Date 9/30/2000		20d. Location - City or Town, State Hurlock, Maryland			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 4 min	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number D26388				29d. Date signed (Month, Day, Year) Sept 27, 2000	
	29b. Signature and title of certifier  MD				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Fackel MD 302 Collins, Hurlock Md. 21643					
State Registrar	31. Date filed (Month, Day, Year) OCT 03 2000				32. Registrar's Signature 					






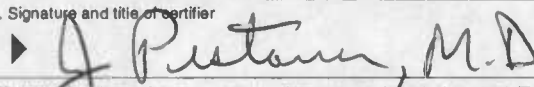
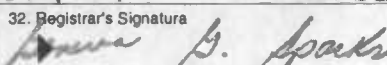
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32760

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Eric Shelton Crumpler</b>				2. Date of Death Month <b>SEPTEMBER</b> Day <b>29</b> , Year <b>2000</b>				3. Time of Death <b>16:05 PM</b>						
	4a. Facility Name (If not institution, give street and number) <b>ROUTE 270 AT ROUTE 370 RAMP</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>				4c. County of Death <b>MONTGOMERY</b>						
Funeral Director	5. Social Security Number <b>214-04-8204</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>17</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 12, 1983</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>						
	10a. State <b>Maryland</b>				10b. County <b>Montgomery</b>				10c. City, Town or Location <b>Rockville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>4315 Pine Tree Road</b>												10f. Zip Code <b>20853</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Student</b>				16b. Kind of Business/Industry <b>High School</b>					
17. Father's Name (First, Middle, Last) <b>Daniel Shelton Crumpler</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Denise Baker</b>									
19a. Informant's Name/Relationship (Type, Print) <b>Daniel Shelton Crumpler/Father</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4315 Pine Tree Road, Rockville, Maryland 20853</b>									
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>				Date <b>October 2, 2000</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>					
21. Signature of Funeral Service Licensee  <b>M00198</b>				22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805</b>											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Multiple Injuries</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Approximate Interval Between Onset and Death															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>											
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month/Day/Year) <b>9/29/00</b>		28b. Time of Injury <b>4pm (Found)</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Driver of vehicle impacts fixed objects</b>					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Rockville, Maryland</b>											
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
29b. Signature and title of certifier  <b>Joseph Pestaner, M.D.</b>						29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 30, 2000</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>															
31. Date filed (Month, Day, Year) <b>OCT 03 2000</b>				32. Registrar's Signature 											

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32761

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harold E. Cropper				2. Date of Death Month Day Year Sept 30, 2000		3. Time of Death 5:45 PM	
	4a. Facility Name (If not institution, give street and number) Springbrook Adventist Nursing Home				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 278-18-7371		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 9, 1923	9. Birthplace (State or Foreign Country) Ohio
	Usual Residence of Decedent							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10a. Street and Number 11119 Lockwood Dr				10f. Zip Code 20901		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Criminal Investigator			16b. Kind of Business/Industry U.S. Army	
17. Father's Name (First, Middle, Last) Oscar W. Cropper				18. Mother's Name (First, Middle, Maiden Surname) Nellie O. Harvey				
19a. Informant's Name/Relationship (Type, Print) Anna I. Cropper/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11119 Lockwood Dr, Silver Spring, MD 20901				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National		Date 10/10/00		20c. Location - City or Town, State Arlington, VA		
21. Signature of Funeral Service Licensee ▶ Alan J. Donnell				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Chronic renal failure Due to (or as a consequence of): b. Congestive heart failure Due to (or as a consequence of): c. Diabetes mellitus Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death 5 years 5 years 10 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier ▶ Paul Armstrong M.D.				29c. License number D43237		29d. Date signed (Month, Day, Year) October 3, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Armstrong, M.D. 14201 Laurel Park Drive, #102, Laurel, Maryland 20707								
31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature B. Sparks						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32762

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Jane Corley				2. Date of Death Month Day Year October 2 2000				3. Time of Death 4:00AM																						
	4a. Facility Name (If not institution, give street and number) 11828 Charles Road				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery																						
Funeral Director	5. Social Security Number 214-48-8830		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.																						
	8. Date of Birth (Month, Day, Year) March 15, 1930		9. Birthplace (State or Foreign Country) Washington, DC		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring																						
Usual Residence of Decedent																															
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 11828 Charles Road		10f. Zip Code 20906		10g. Citizen of What Country? USA																									
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White																							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Copy Editor				16b. Kind of Business/Industry Federal Government																							
17. Father's Name (First, Middle, Last) Lloyd W. Wineberg						18. Mother's Name (First, Middle, Maiden Surname) Isabell McQuown																									
19a. Informant's Name/Relationship (Type, Print) Frederick W. Corley / Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11828 Charles Road, Silver Spring, Maryland 20906																											
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park		Date 10/05/00		20c. Location - City or Town, State Rockville, Maryland																							
21. Signature of Funeral Service Licensee				22. Name and Address of Facility HINES-RINALDI 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MARYLAND 20904																											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																															
<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>Metastatic signet ring adenocarcinoma of colon</td> <td>7 months</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>Colon cancer</td> <td>1.5 years</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="3"></td> </tr> </table>											Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Metastatic signet ring adenocarcinoma of colon	7 months	Due to (or as a consequence of):			b.	Colon cancer	1.5 years	Due to (or as a consequence of):			c.	Due to (or as a consequence of):			d.			
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Metastatic signet ring adenocarcinoma of colon	7 months																												
	Due to (or as a consequence of):																														
	b.	Colon cancer	1.5 years																												
	Due to (or as a consequence of):																														
c.	Due to (or as a consequence of):																														
d.																															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes																															
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																															
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																															
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																															
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																													
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																							
28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																											
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																															
29b. Signature and title of Certifier Linda M. Burrell				29c. License number D35996				29d. Date signed (Month, Day, Year) October 3, 2000																							
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Linda M. Burrell, M.D. 2730 University Blvd., #400, Wheaton, Maryland 20902																															
31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature B. Sparks																													

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32763

Baltimore, Maryland 21215-0020

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Division of Vital Records, P.O. Box 68760,

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Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) James Cooperman						2. Date of Death Month Day Year September 28, 2000				3. Time of Death 6:00am	
4a. Facility Name (If not institution, give street and number) 9106 Brierly Road						4b. City, Town, or Location of Death Chevy Chase				4c. County of Death Montgomery	
5. Social Security Number 194-05-5313		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) November 4, 1912	
9. Birthplace (State or Foreign Country) Pennsylvania											
Usual Residence of Decedent											
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Chevy Chase				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 9106 Brierly Road						10f. Zip Code 20815		10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chemical Engineer				16b. Kind of Business/Industry United States State Department			
17. Father's Name (First, Middle, Last) Jacob Cooperman						18. Mother's Name (First, Middle, Maiden Surname) Alice Gordon					
19a. Informant's Name/Relationship (Type, Print) Tillie Cooperman / Wife						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9106 Brierly Road, Chevy Chase, MD 20815					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Memorial Gardens		Date 10/02/00		20c. Location - City or Town, State Olney, MD			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility Danzansky Goldberg Memorial Chapels, Inc 1170 Rockville Pike, Rockville, MD 20852					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>Arteriosclerotic heart disease</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death <u>years</u>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 						29c. License number D23911		29d. Date signed (Month, Day, Year) September 28, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David A. Bliss 9410 Old Georgetown Road Bethesda, MD 20814											
31. Date filed (Month, Day, Year) OCT 04 2000				32. Registrar's Signature 							

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

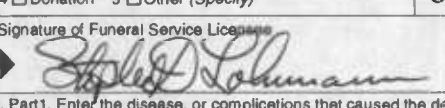
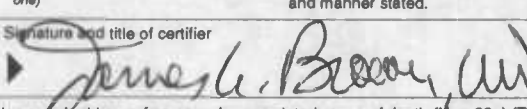

State of Maryland / Department of Health and Mental Hygiene

00 32764

Amend #18, 10/4/2000, BMW, Montg. Co.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>STEPHEN MARK COHEN</b>			2. Date of Death Month Day Year <b>SEPTEMBER 29, 2000</b>		3. Time of Death <b>1:30 AM</b>										
	4a. Facility Name (If not institution, give street and number) <b>10312 BLOOM Drive</b>			4b. City, Town, or Location of Death <b>DAMASCUS</b>		4c. County of Death <b>MONTGOMERY</b>										
Funeral Director	5. Social Security Number <b>213-78-0619</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>42</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 25, 1958</b>										
	9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>															
Usual Residence of Decedent																
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Damascus</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
10a. Street and Number <b>10312 Bloom Drive</b>				10f. Zip Code <b>20872</b>		10g. Citizen of What Country? <b>United States</b>										
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Computer Programmer</b>		16b. Kind of Business/Industry <b>Food Retail</b>										
17. Father's Name (First, Middle, Last) <b>Burton Seymour Cohen</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margot Adele Herskowitz</b>												
19a. Informant's Name/Relationship (Type, Print) <b>Elizabeth Joyce Cohen / Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10312 Bloom Drive, Damascus, Maryland 20872</b>												
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory Inc.</b>		Date <b>10-2-2000</b>		20c. Location - City or Town, State <b>Beltsville, Maryland</b>										
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Rapp Funeral and Cremation Services, Stephen D. Lohrmann P.A., 933 Gist Ave., Silver Spring, Maryland 20910</b>												
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>Metastatic Sigmoid Colon Carcinoma</b></td> <td>Approximate Interval Between Onset and Death <b>39 Months</b></td> </tr> <tr> <td>b. _____</td> <td></td> </tr> <tr> <td>c. _____</td> <td></td> </tr> <tr> <td>d. _____</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Metastatic Sigmoid Colon Carcinoma</b>	Approximate Interval Between Onset and Death <b>39 Months</b>	b. _____		c. _____		d. _____	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>Metastatic Sigmoid Colon Carcinoma</b>	Approximate Interval Between Onset and Death <b>39 Months</b>														
	b. _____															
	c. _____															
	d. _____															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred												
28f. Location (Street and Number or Rural Route Number, City or Town, State)																
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																
29b. Signature and title of certifier 				29c. License number <b>D07285</b>		29d. Date signed (Month, Day, Year) <b>September 29, 2000</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James A. Brown, M.D.; 9707 Medical Center Drive, Rockville, Maryland 20850</b>																
31. Date filed (Month, Day, Year) <b>OCT 04 2000</b>		32. Registrar's Signature 														



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32765

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Estelle Cohen</b>		2. Date of Death Month <b>Oct.</b> Day <b>2,</b> Year <b>2000</b>		3. Time of Death <b>2:55A.</b>
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>		4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>
Funeral Director	5. Social Security Number <b>063-01-6150</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Aug. 14, 1918</b>		9. Birthplace (State or Foreign Country) <b>New York</b>		
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>
	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>1136 Loxford Terrace</b>		10f. Zip Code <b>20901</b>		10g. Citizen of What Country? <b>United States</b>
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Office Manager</b>		16b. Kind of Business/Industry <b>United States Gov'n't</b>
	17. Father's Name (First, Middle, Last) <b>Samuel Saperstein</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lena Manius</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Abner B. Cohen (husband)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King David Memorial Garden 10/3/00 Falls Church, Virginia</b>		
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Pulmonary embolism</b> Due to (or as a consequence of): <b>chronic Pulmonary Fibrosis</b> Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>hypertension Heart failure</b>				Approximate Interval Between Onset and Death <b>years</b> <b>years</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cor Pulmonale</b> <b>Pulmonary embolism</b> <b>hypertension Heart failure</b>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>M</b> 28b. Time of Injury <b>1</b> Yes 2 <input type="checkbox"/> No 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier 		29c. License number <b>25808</b>		29d. Date signed (Month, Day, Year) <b>October 2, 2000</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Herman Segal, M.D. 10313 Georgia Avenue, #306 Silver Spring, Maryland 20902</b>				
State Registrar	31. Date filed (Month, Day, Year) <b>OCT 03 2000</b>		32. Registrar's Signature 		





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State of Maryland / Department of Health and Mental Hygiene

00 32766

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SARAH GOODE COGHILL</b>				2. Date of Death Month <b>10</b> Day <b>3</b> Year <b>2000</b>		3. Time of Death <b>3:35 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>P.G. HOSPITAL</b>				4b. City, Town, or Location of Death <b>CHEVERLY</b>		4c. County of Death <b>P.G.</b>		
Funeral Director	5. Social Security Number <b>578-22-8942</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JULY 28, 1912</b>		
	9. Birthplace (State or Foreign Country) <b>N. CAROLINA</b>		10a. State <b>MD</b>		10b. County <b>P.G.</b>		10c. City, Town or Location <b>BEAVER HEIGHTS</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1516 BEAVER HEIGHTS LANE</b>		10f. Zip Code <b>20743</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6TH</b>		College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FOOD SERVICE</b>		16b. Kind of Business/Industry <b>N/A</b>			
17. Father's Name (First, Middle, Last) <b>JOHN MCWILLIAMS</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>MARJIANA (UNKNOWN)</b>					
19a. Informant's Name/Relationship (Type, Print) <b>MARGARET G. JOHNSON DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2537 HIGH ST. S.E. WASH, DC. 20020</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MARYLAND NATIONAL</b>		Date <b>10/9/00</b>		20c. Location - City or Town, State <b>LAUREL, MD.</b>			
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>AUSTIN ROYSTER FUNERAL HOME</b> <b>3821 14TH ST. N.W. WASH, DC. 20011</b>					
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):		b. <b>RENAL FAILURE</b> Due to (or as a consequence of):		c. <b>RHABDOMYOSIS</b> Due to (or as a consequence of):		d.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D0055703</b>		29d. Date signed (Month, Day, Year) <b>10/3/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TSION BERNARD</b>		3001 HOSPITAL DR, CHEVERLY, MD. 20785 <b>301-618-6100</b>							
31. Date filed (Month, Day, Year) <b>OCT 06 2000</b>		32. Registrar's Signature <i>[Signature]</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

00 32767

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sylvia Leah Citrin				2. Date of Death Month Day Year October 1, 2000		3. Time of Death 3:00pm	
	4a. Facility Name (If not institution, give street and number) Brighton Gardens -5550 Tuckerman Lane				4b. City, Town, or Location of Death North Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 098-28-1064		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) December 6, 1907	
	9. Birthplace (State or Foreign Country) New York		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location North Bethesda	
To Be Completed by Funeral Director	10e. Street and Number 5550 Tuckerman Lane		10f. Zip Code 20852		10g. Citizen of What Country? United States		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		17. Father's Name (First, Middle, Last) Abraham Rosenhaus	
	18. Mother's Name (First, Middle, Maiden Surname) Sophie Gelfand		19a. Informant's Name/Relationship (Type, Print) Cynthia Janis / Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7541 Coddle Harbor Lane, Potomac, Maryland 20854		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) New Cedar Park Cemetery		20c. Location - City or Town, State Paramus, New Jersey		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Danzansky Goldberg Memorial Chapel, Inc 1170 Rockville Pike, Rockville, MD 20852	
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Congestive heart disease Due to (or as a consequence of): b. myocardial infarction Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death years 1 month		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
State Registrar	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Ellen M Pinholt MD		29c. License number D 51015		29d. Date signed (Month, Day, Year) October 4, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ellen M Pinholt MD 5530 Wisconsin Ave #1045 Chevy Chase MD 20815		31. Date filed (Month, Day, Year) OCT 06 2000		32. Registrar's Signature B. Sparks			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32768

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ruth Edna Money Cipione</b>				2. Date of Death Month <b>Oct.</b> Day <b>1,</b> Year <b>2000</b>		3. Time of Death <b>6:15 PM.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Bedford Court</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>579-22-5767</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 12, 1915</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3701 International Drive</b>				10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nursing Assistant</b>			16b. Kind of Business/Industry <b>Medical</b>	
17. Father's Name (First, Middle, Last) <b>Clayton Harrison Money</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Eliza Wright</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Christine A. Cox - Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12755 Turquoise Terr., Silver Spring, Md. 20904</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>National Crematory</b>		Date <b>10/5/2000</b>		20c. Location - City or Town, State <b>Falls Church, Va.</b>
21. Signature of Funeral Service Licensee <b>Thomas E. Honnaker</b>				22. Name and Address of Facility <b>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW., Washington, D.C. 20016</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Carcinoma of the Gallbladder With Metastasis</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <b>Gilbert Hurwitz, M.D.</b>				29c. License number <b>D05585</b>		29d. Date signed (Month, Day, Year) <b>Oct. 5, 2000</b>		
30. Name and address of person who completed cause of death (from 23a) (Type, Print) <b>Gilbert E. Hurwitz, MD., 1800 Eye St. NW., Washington, D.C. 20006-5407</b>								
31. Date filed (Month, Day, Year) <b>OCT 06 2000</b>				32. Registrar's Signature <b>Beverly B. Sparks</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32769

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James Waldo Church				2. Date of Death Month Day Year September 29, 2000		3. Time of Death 9:04 am	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 482-14-1863	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec 1, 1922		9. Birthplace (State or Foreign Country) Nebraska
	Usual Residence of Decedent							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Wheaton		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10a. Street and Number 2115 Arcola Avenue				10f. Zip Code 20902		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Naval Architect		16b. Kind of Business/Industry U.S. Department of the Navy		
17. Father's Name (First, Middle, Last) Guy Irving Church				18. Mother's Name (First, Middle, Maiden Surname) Olive Claire Cushing				
19a. Informant's Name/Relationship (Type, Print) Mary Kelleher Church/ Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2115 Arcola Ave., Wheaton, MD 20902				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date 10/3/00		20c. Location - City or Town, State Silver Spring, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive heart failure Due to (or as a consequence of): b. Cardiomyopathy Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 						
		29c. License number 40365		29d. Date signed (Month, Day, Year) September 30, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER J. SABIA MD 10313 Georgia Ave #308 Silver Spring, Md 20902								
31. Date filed (Month, Day, Year) OCT 02 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 + 1



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 32770

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Yue Fook Chui				2. Date of Death Month Day Year October 2, 2000		3. Time of Death 5:48 PM		
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 097-72-9595		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) June 5, 1927	9. Birthplace (State or Foreign Country) China	
	Usual Residence of Decedent								
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 1200 Canyon Road				10f. Zip Code 20904		10g. Citizen of What Country? China			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Asian		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sailor			16b. Kind of Business/Industry Merchant Shipping		
17. Father's Name (First, Middle, Last) Sun Chui				18. Mother's Name (First, Middle, Maiden Surname) Mui Yu					
19a. Informant's Name/Relationship (Type, Print) Annie Yeh / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 Canyon Road, Silver Spring, MD 20904					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Crematory 10/11/00		20c. Location - City or Town, State Brentwood, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Septic Shock Due to (or as a consequence of): b. Severe Pancytopenia Due to (or as a consequence of): c. Relapsed Multiple Myeloma Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 1 day 3 months 4 years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of certifier 		29c. License number D41828		29d. Date signed (Month, Day, Year) October 2, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CLARA CHAN, MD. 9801 Georgia Ave #337 Silver Spring, MD 20902									
31. Date filed (Month, Day, Year) OCT 05 2000		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32771

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Daisy Oretta Campbell</b>				2. Date of Death Month <b>October</b> Day <b>2</b> Year <b>2000</b>		3. Time of Death <b>10:30 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>3516 Hargo Street</b>				4b. City, Town, or Location of Death <b>Wheaton</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>236-30-1333</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>September 13, 1915</b>		9. Birthplace (State or Foreign Country) <b>West Virginia</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Wheaton</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. Street and Number <b>3516 Hargo Street</b>				10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>Francis Logan Spencer</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Virginia Bailes</b>				
19a. Informant's Name/Relationship (Type, Print) <b>James Michael Campbell/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19048 Steeple Place, Germantown, Maryland 20874</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Downtown Chapel Cemetery</b>		Date <b>October 7, 2000</b>		20c. Location - City or Town, State <b>Nettie, West Virginia</b>		
21. Signature of Funeral Service Licensee <i>Robert A. Pumphrey</i> M00846				22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. <b>Gastro-Intestinal Hemorrhage</b>					Approximate Interval Between Onset and Death <b>3 Days</b>	
		Due to (or as a consequence of):						
		b. <b>Gastritis</b>					<b>10 Days</b>	
		Due to (or as a consequence of):						
		c.						
		Due to (or as a consequence of):						
		d.						
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Michael R. Dobridge, M.D.</i>				29c. License number <b>D01138</b>		29d. Date signed (Month, Day, Year) <b>October 2, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael R. Dobridge, M.D., 13975 Connecticut Avenue #308, Silver Spring, Maryland 20906</b>								
31. Date filed (Month, Day, Year) <b>OCT 03 2000</b>				32. Registrar's Signature <i>James B. Sparks</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32772

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Martha Campbell

2. Date of Death

Month Day Year  
OCTOBER 02, 2000

3. Time of Death

8:24 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Berlin Nursing &amp; Rehabilitation Center

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

5. Social Security Number

264-24-8085

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 25, 1905

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Worcester

10c. City, Town or Location

Whaleysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11101 Hall Road

10f. Zip Code

21872

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4th grade

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

laborer

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

Alice Abraham

19a. Informant's Name/Relationship (Type, Print)

Albert Hilliard, Sr./nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11101 Hall Road - Whaleysville, MD 21872

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Paul UM Ch. Cemetery 10/07/00 Berlin, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOLLEY MEMORIAL CHAPEL

21801

1213 Jersey Road - Salisbury, MD

Physician  
/Medical  
Examiner23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Atherosclerosis

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Semiility

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D02026

29d. Date signed (Month, Day, Year)

Oct 3-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. FEDERICO ARTHES, 46 TEAL CIRCLE, BERLIN, MD 21811

31. Date filed (Month, Day, Year)

OCT 04 2000

32. Registrar's Signature

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

CAMPBELL, MARTHA

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32773

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Irene Dessie DeYoung</b>				2. Date of Death Month Day Year <b>9/28/2000</b>		3. Time of Death <b>13:35 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Atlantic General Hospital</b>				4b. City, Town, or Location of Death <b>Berlin</b>		4c. County of Death <b>Worcester</b>	
Funeral Director	5. Social Security Number <b>204-03-9182</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	8. Data of Birth (Month, Day, Year) <b>2/2/1921</b>	9. Birthplace (State or Foreign Country) <b>PA</b>			
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Ocean City</b>		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number <b>12107 A. Angler RD</b>				10f. Zip Code <b>21842</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Homemaker</b>		
17. Father's Name (First, Middle, Last) <b>Peter Lubic</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Dessie Sheaffer</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Kathleen Deimler - Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12107 A. Angler RD, Ocean City, MD 21842</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Hill Cemetery</b>		20c. Location - City or Town, State <b>Grand Rapids, MI</b>		20d. Date <b>9/30/00</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>The Burbage Funeral Home 108 William Street Berlin, MD 21811</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 60%;"> <p>a. <b>Acute Renal Failure</b> Due to (or as a consequence of):</p> <p>b. <b>Sepsis</b> Due to (or as a consequence of):</p> <p>c. <b>Vasculitis</b> Due to (or as a consequence of):</p> <p>d. <b></b> Due to (or as a consequence of):</p> </div> </div>								
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>110653714</b>		29d. Date signed (Month, Day, Year) <b>09/28/2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jeffrey Matzoni, DO 9714 Healthway Drive Berlin, MD 21811</b>								
31. Date filed (Month, Day, Year) <b>OCT 02 2000</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

15

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32774

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sarah Catherine Dowling

2. Date of Death

Month 9 Day 30 Year 00 10:02 p.m.

3. Time of Death

4a. Facility Name (If not institution, give street and number)

603 Second Street

4b. City, Town, or Location of Death

Pocomoke

4c. County of Death

Worcester

Funeral  
Director

5. Social Security Number

262-46-5082

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 09-14-34

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Pocomoke City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

603 Second Street

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LINE-WORKER

16b. Kind of Business/Industry

Campbell Soup Co.

17. Father's Name (First, Middle, Last)

James Dowling

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle

19a. Informant's Name/Relationship (Type, Print)

Joan Young/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

603 Second St Pocomoke MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Macedonia Memorial PK

Date

10/7/00

20c. Location - City or Town, State

Westover, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BENNIE SMITH FUNERAL HOME  
P.O. BOX 331  
POCOMOKE CITY, MARYLAND 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. primary biliary tract carcinoma  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

COPD

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mary L. Fleury MD

29c. License number

D24871

29d. Date signed (Month, Day, Year)

10/6/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Mary L. Fleury 305 10th Street, Pocomoke City MD 21851

31. Date filed (Month, Day, Year)

OCT 10 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Legible. 32775

Legible. 32775

## Reg. No.

Physician /Medical Examiner

Funeral Director

Physician /Medical Examiner

State Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

1. Decedent's Name (First, Middle, Last)

Theresa Marie Dorsie

2. Date of Death

Month Day Year

September 30, 2000

3. Time of Death

5:45 a.m.

4a. Facility Name (If not institution, give street and number)

17101 Thorntondale Court

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

194-22-1011

6. Sex

1 Male 2 Female

7. Age (In yrs. last birthday)

71 Yrs.

8. Date of Birth (Month, Day, Year)

March 6, 1929

9. Birthplace (State or Foreign Country)

Pennsylvania

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Olney

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

17101 Thorntondale Court

10f. Zip Code

20832

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Accounting Clerk

16b. Kind of Business/Industry

University of Maryland

17. Father's Name (First, Middle, Last)

Michael Garone

18. Mother's Name (First, Middle, Maiden Surname)

Mary Botta

19a. Informant's Name/Relationship (Type, Print)

Edward C. Dorsie / husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17101 Thorntondale Court, Olney, Maryland 20832

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

John E. Barber

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Ovarian Cancer

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Frederick G. Barr MD

29c. License number

D22775

29d. Date signed (Month, Day, Year)

October 1, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick G. Barr, MD 2730 University Blvd., W, Silver Spring, MD 20902

31. Date filed (Month, Day, Year)

OCT 02 2000

32. Registrar's Signature

B. Sparks



amend item 23a,27 per me G788 10/19/00 yf

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOSEPH JAMES DOOLING				2. Date of Death Month Day Year SEPTEMBER 27, 2000				3. Time of Death 1830 PM		
	4a. Facility Name (If not institution, give street and number) 6404 WEATHERBY COURT				4b. City, Town, or Location of Death FREDERICK CITY				4c. County of Death FREDERICK		
Funeral Director	5. Social Security Number 236-15-6769		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 36 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 9, 1964		9. Birthplace (State or Foreign Country) DC		
	10a. State Maryland				10b. County Frederick				10c. City, Town or Location Frederick		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 6404 Weatherby Court				10f. Zip Code 21703		10g. Citizen of What Country? USA	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			
14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Residential Counselor			
16b. Kind of Business/Industry Health Care				17. Father's Name (First, Middle, Last) Clarence Robert Dooling, Jr.				18. Mother's Name (First, Middle, Maiden Surname) O. Patricia Hollis			
19a. Informant's Name/Relationship (Type, Print) O. Patricia Dooling (mother)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2209 Glenallen Avenue #202 Silver Spring, MD 20906				20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			
20b. Place of Disposition (Name of cemetery, crematory or other place) St. Peter's Cemetery				20c. Location - City or Town, State Harpers Ferry, West Virginia				20d. Date Oct. 2, 2000			
21. Signature of Funeral Service Licensee Robert E. Ramsey				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. FOCAL MYOCARDIAL FIBROSIS Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Maryland P. KOREN				29c. License number OCME			
29d. Date signed (Month, Day, Year) SEPTEMBER 28, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND P. KOREN 111 Penn Street, Baltimore, Maryland 21201				31. Date filed (Month, Day, Year) OCT 04 2000			
32. Registrar's Signature B. Sparks				33. State Registrar State Registrar				34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32777

Amend #26, 10/4/2000, BMW, Montg. Co.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY SANDSTROM OILARD

2. Date of Death

September 29, 2000

3. Time of Death

2225

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2128 Drury Road

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

200-22-9284

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 3, 1926

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10e. State

PA

10b. County

Tioga

10c. City, Town or Location

Arnot

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

P.O. Box 151

10f. Zip Code

16911

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Food Service Supervisor

16b. Kind of Business/Industry

Public School System

17. Father's Name (First, Middle, Last)

Anton F. Sandstrom

18. Mother's Name (First, Middle, Maiden Surname)

Mary Eadie

19a. Informant's Name/Relationship (Type, Print)

Sandra Rosenberg/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2128 Drury Road Silver Spring, MD 20906

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ft. Lincoln Crematory

Date

10/03/00

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home, Inc.

11800 New Hampshire Ave. Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CARCINOMA OF LUNG

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

015236

29d. Date signed (Month, Day, Year)

September 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARL E. MARGOLIS, M.D. (One) 1125 Rockview Pike, Rockville, MD 20852

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 04 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

20





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State of Maryland / Department of Health and Mental Hygiene

00 32778

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Douglas Leo Detrick				2. Date of Death Month Day Year September 26, 2000		3. Time of Death 3:35PM	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 220-58-3341	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 48 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 10, 1951		9. Birthplace (State or Foreign Country) Iowa
	Usual Residence of Decedent							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 18905 Tributary Lane				10f. Zip Code 20879		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrical Contractor		16b. Kind of Business/Industry Self-Employed		
17. Father's Name (First, Middle, Last) Clyde Detrick				18. Mother's Name (First, Middle, Maiden Surname) Delores Krupp				
19a. Informant's Name/Relationship (Type, Print) Jacqueline M. Detrick/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18905 Tributary Lane, Gaithersburg, MD 20879				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. 30, 2000 Bethesda, Maryland		20c. Location - City or Town, State Bethesda, Maryland		
21. Signature of Funeral Service Licensee D. E. Perry M00803				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. NON SMALL CELL lung cancer Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death 8 months								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier D. E. Perry				29c. License number D 35635		29d. Date signed (Month, Day, Year) SEPTEMBER 26, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH KAPLAN, MD 1811 Prince Philip Dr OLNEY, MD 20832								
31. Date filed (Month, Day, Year) OCT 02 2000				32. Registrar's Signature B. Sparks				



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32779

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Camde Nguyen Dang</b>				2. Date of Death Month Day Year <b>Sept. 29, 2000</b>				3. Time of Death <b>8:45am</b>					
4a. Facility Name (If not institution, give street and number) <b>Prince George Hospital Center</b>				4b. City, Town, or Location of Death <b>Cheverly</b>				4c. County of Death <b>Prince Georges</b>					
5. Social Security Number <b>215-94-4092</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>Nov. 23, 1931</b>		9. Birthplace (State or Foreign Country) <b>Vietnam</b>	
Usual Residence of Decedent													
10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Greenbelt</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>7905 Ora Glen Drive</b>				10f. Zip Code <b>20770</b>				10g. Citizen of What Country? <b>United States</b>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Asian</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Home</b>					
17. Father's Name (First, Middle, Last) <b>Vung T. Nguyen</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Oanh Ho</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Tri N. Dang/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7905 Ora Glen Drive Greenbelt, MD 20770</b>									
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven</b>				Date <b>10/02/00</b>		20c. Location - City or Town, State <b>Silver Spring, MD</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring, MD 20904</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Systemic Inflammatory Response Syndrome</b> Due to (or as a consequence of): b. <b>Sepsis</b> Due to (or as a consequence of): c. <b>Cardiointestinal Bleeding</b> Due to (or as a consequence of): d.												Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier 				29c. License number <b>D30318</b>				29d. Date signed (Month, Day, Year) <b>9/29/00</b>					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>James Catavenis, MD 3001 Hospital Drive Cheverly, MD 20722</b>													
31. Date filed (Month, Day, Year) <b>OCT 02 2000</b>				32. Registrar's Signature 									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32780

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOUGLAS DODD

2. Date of Death

10 10 00

3. Time of Death

7-23PM

4a. Facility Name (If not institution, give street and number)

LAUREL REGIONAL HOSPITAL

4b. City, Town, or Location of Death

LAUREL

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

217-44-7014

6. Sex

M 20 F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

6-16-47

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 Yes X No

10e. Street and Number

3355 Sudlersville S.

10f. Zip Code

20724

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 X Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanical Contractor

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

William Andrew Dodd, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Judith Purks

19a. Informant's Name/Relationship (Type, Print)

Mary R. Dodd/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3355 Sudlersville S. Laurel, MD 20724

20a. Method of Disposition

1 Burial 2 X Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

10/16/00

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

MO1103

22. Name and Address of Facility

Donaldson Funeral Home, P.A.

313 Talbott Avenue, Laurel, Maryland 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

ACUTE MYOCARDIAL INFARCTION

e.

Due to (or as a consequence of):

CORONARY ARTERY DISEASE

b.

Due to (or as a consequence of):

ARTERIO SCLEROSIS

c.

Due to (or as a consequence of):

HYPERLIPIDEMIA

d.

7 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

DIABETES MELLITUS.

23b. Did tobacco use contribute to the cause of death?

1 X Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 X No

25. Was case referred to medical examiner?

1 Yes 2 X No

26. Place of Death (Check only one)

Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 X Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

X

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Abdul Nayeem M.D.

29c. License number

D 21294

29d. Date signed (Month, Day, Year)

10/10/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABDUL NAYEEM, M.D. 3450 FORT MEADE ROAD, suite 100 LAUREL, MD. 20724

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32781

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM L. DUNTON</b>				2. Date of Death Month Day Year <b>OCT 06 2000</b>		3. Time of Death <b>1535</b>	
	4a. Facility Name (If not institution, give street and number) <b>HOWARD COUNTY GENERAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>COLUMBIA</b>		4c. County of Death <b>HOWARD</b>	
Funeral Director	5. Social Security Number <b>216-40-1851</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 22, 1943</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Woodstock</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>10532 Chesham Way</b>		10f. Zip Code <b>21163</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Transportation Specialist</b>		16b. Kind of Business/Industry <b>U. S. Department of Agriculture</b>			
	17. Father's Name (First, Middle, Last) <b>William M. Dunton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ruth H. Doney</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Dianne L. Dunton / spouse</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10532 Chesham Way Woodstock, MD. 21163</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crestlawn Mem. Gardens</b>		Date <b>Oct. 10 2000</b>		20c. Location - City or Town, State <b>Marriottsville, MD.</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS, ATRIAL FIBRILLATION, HYPERLIPIDEMIA</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Marshall Freedman, D.O.</b>				29c. License number <b>H37211</b>		29d. Date signed (Month, Day, Year) <b>OCT. 6, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Marshall Freedman, 2 KNOLL N, COLUMBIA MD 21045</b>								
31. Date filed (Month, Day, Year) <b>OCT 10 2000</b>		32. Registrar's Signature <b>G. Sparks</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32782

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Irene Martin Edwards</b>				2. Date of Death Month Day Year <b>Sept. 28, 2000</b>		3. Time of Death <b>7:20 AM.</b>	
	4a. Facility Name (If not institution, give street and number) <b>5 Enid Court</b>				4b. City, Town, or Location of Death <b>Potomac</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>501-09-8300</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug. 30, 1917</b>	9. Birthplace (State or Foreign Country) <b>North Carolina</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Chevy Chase</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>8101 Connecticut Ave., #N509</b>				10f. Zip Code <b>20815</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrative Assistant</b>		16b. Kind of Business/Industry <b>U.S. Senate</b>		
17. Father's Name (First, Middle, Last) <b>Patrick J. Martin</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Patricia Carpenter</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Victoria L. Edwards (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 Enid Court Potomac, MD 20854</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>National Crematory</b>		Date <b>10-02</b>		20c. Location - City or Town, State <b>Falls Church, VA</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>JOSEPH GAWLER'S SONS, INC. 5130 Wisconsin Ave., NW Washington, DC 20016</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Colon Cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>None</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>daughter's residence</b>						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D48043</b>		29d. Date signed (Month, Day, Year) <b>September 29, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sharon A. Scanlon, MD 5530 Wisconsin Ave., Ste. 930 Chevy Chase, MD 20815</b>								
31. Date filed (Month, Day, Year) <b>OCT 6 2 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32783

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN J. FALLON</b>				2. Date of Death Month <b>10</b> Day <b>1</b> Year <b>2000</b>		3. Time of Death <b>1510</b>
	4a. Facility Name (If not institution, give street and number) <b>13299 ROLLIE RD. EAST</b>				4b. City, Town, or Location of Death <b>BISHOPVILLE</b>		4c. County of Death <b>WORCESTER</b>
Funeral Director	5. Social Security Number <b>147-22-2101</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>8-2-31</b>	9. Birthplace (State or Foreign Country) <b>NJ</b>
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State <b>MD.</b>	10b. County <b>WORCESTER</b>		10c. City, Town or Location <b>BISHOPVILLE</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>13299 ROLLIE RD. EAST</b>			10f. Zip Code <b>21813</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1948</b> <b>1972</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ADJUSTER</b>			16b. Kind of Business/Industry <b>INSURANCE</b>	
	17. Father's Name (First, Middle, Last) <b>JOHN J. FALLON SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARGARET FAHEY</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>JUDITH FALLON/ SPOUSE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13299 ROLLIE RD. EAST BISHOPVILLE, MD. 21813</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD. VETERANS CEM.</b>		Date <b>10-4</b>	20c. Location - City or Town, State <b>HURLOCK, MD.</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>ULLRICH FUNERAL HOME BERLIN, MD. 21811</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Chronic obstructive pulmonary disease</b> Due to (or as a consequence of): b. <b>LUNG Cancer</b> Due to (or as a consequence of): c. <b>Cervical Cancer</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>16 months</b>						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
State Registrar	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State)				
571	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
	29b. Signature and Title of certifier 				29c. License number <b>DO47676</b>		29d. Date signed (Month, Day, Year) <b>10/2/00</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BISHOP TOLLEMAN ST 33 HIGHTWAY DR BIRCH MD 21811</b>						
31. Date filed (Month, Day, Year) <b>OCT 02 2000</b>		32. Registrar's Signature 					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32784

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LaVelta E. Flora

2. Date of Death

Month Day Year  
10 02 2000

3. Time of Death

1:20 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Hartley Hall Nursing Home

4b. City, Town, or Location of Death

Pocomoke City

4c. County of Death

Worcester

5. Social Security Number

478-68-5589

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

03/08/1915

9. Birthplace (State or Foreign Country)

Kansas

Usual Residence of Decedent

10a. State

MD

10b. County

Somerset

10c. City, Town or Location

Westover

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7155 Elmo Dryden Road

10f. Zip Code

21871

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Joseph Oxley

18. Mother's Name (First, Middle, Maiden Surname)

Emma Long

19a. Informant's Name/Relationship (Type, Print)

Ellen Moyer (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7171 Elmo Dryden Rd., Westover, MD 21871

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Grove Memorial Church Cemetery

Date

10/05/00 Westover, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Michael A. Dean MD1129

22. Name and Address of Facility

Holloway Melson Funeral Home, P.A.

103 Linden Ave., Pocomoke City, MD 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

End Stage Alzheimer's Dementia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinson's Disease

Hypothyroidism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide 6 ☐ Could not be determined4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Gregorio M. Belloso M.D.

29c. License number

D29505

29d. Date signed (Month, Day, Year)

10-2-2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DR., SALISBURY, MD 21801

31. Date filed (Month, Day, Year)

OCT 03 2000

32. Registrar's Signature

Benita G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32785

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HOWARD FELTON</b>				2. Date of Death Month Day Year <b>SEPTEMBER 25, 2000</b>		3. Time of Death <b>1:07 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>UNIVERSITY OF MARYLAND HOSPITAL BALTIMORE, MARYLAND</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>BALTIMORE CITY</b>	
Funeral Director	5. Social Security Number <b>226-34-3943</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 3, 1924</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Pocomoke</b>	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>106 Cherry Street</b>		10f. Zip Code <b>21851</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Gardener</b>		16b. Kind of Business/Industry <b>Own Business</b>		17. Father's Name (First, Middle, Last) <b>Charlie Felton</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Bertha Wood</b>		19a. Informant's Name/Relationship (Type, Print) <b>Mable Felton / wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>106 Cherry Street, Pocomoke, Maryland 21851</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Veterans Cemetery</b>		20c. Location - City or Town, State <b>10/2/2000 Hurlock, Maryland</b>		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Asystole</b> Due to (or as a consequence of):  b. <b>Hypoxemia</b> Due to (or as a consequence of):  c. <b>Diffuse Alveolar Hemorrhage</b> Due to (or as a consequence of):  d.		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>R. Hansalia, MD</b>		
29c. License number <b>13125</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 25, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RIPLE HANSALIA, MD, 22 South Greene Street, BALTIMORE, MARYLAND 21201</b>		31. Date filed (Month, Day, Year) <b>OCT 02 2000</b>		
32. Registrar's Signature 		33. Registrar's Title <b>Registrar</b>		34. Registrar's Name <b>State Registrar</b>		35. Registrar's Address <b>Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020</b>		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32786

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alice Barrett Francis

2. Date of Death

Month Day Year  
September 26, 2000

3. Time of Death

20:45

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

199-14-6846

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
December 27, 1922

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11309 Gainsborough Road

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker/Artist

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Lawrence T. Barrett

18. Mother's Name (First, Middle, Maiden Surname)

Jeanette Walters

19a. Informant's Name/Relationship (Type, Print)

M. Constance Francis/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4202 South 35th Street, Arlington, Virginia 22206

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

September  
28, 2000

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00846

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or combination of diseases that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Subarachnoid Hemorrhage

Approximate  
Interval Between  
Onset and Death

6 days

Due to (or as a consequence of):

b. Hypertension

years

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
investigation 6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D46052

29d. Date signed (Month, Day, Year)

9/26/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sjoerd Bech, MD, 8600 Old Georgetown Road, Bethesda, MD 20814

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 02 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202-343-2020.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

20

Francis, Alice 9/26/00 20:45.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #10E, 26 PER HY, INFORMANT G789 11-13-00 **Certificate of Death**

Reg. No.

00 32787

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Irma Corinne Fisher				2. Date of Death Month: October Day: 3, Year: 2000				3. Time of Death 1235am	
	4a. Facility Name (If not institution, give street and number) 812 Crothers La.				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 320-22-7505		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		If Under 1 Year Months: Days:		8. Date of Birth (Month, Day, Year) May 12, 1923	
	9. Birthplace (State or Foreign Country) SC									
To Be Completed by Funeral Director	Usual Residence of Decedent									
	10a. State MD		10b. County Montgomery		10c. City, Town or Location Rockville				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 258 CONGRESSIONAL LANE APT. #103 <del>812 Crothers La.</del> ROCKVILLE, MD 20852				10f. Zip Code 20852		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College 4 (4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Grants Administrator				16b. Kind of Business/Industry Government			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Lawrence M. Fisher				18. Mother's Name (First, Middle, Maiden Surname) Herma Yoder					
	19a. Informant's Name/Relationship (Type, Print) Lawrence Fisher Sr./Brother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13107 Cherub Way, Fredericksburg, VA 22408					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date Oct 5 2000		20c. Location - City or Town, State Beltsville, MD			
	21. Signature of Funeral Service Licensee Beverly L. Hellett				22. Name and Address of Facility Fapp Funeral & Cremation Services 933 Gist Avenue Silver Spring, MD					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Endometrial Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Approximate Interval Between Onset and Death 3 months									
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Leon C. Hwang				29c. License number D45880		29d. Date signed (Month, Day, Year) October 03, 2000		
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leon C. Hwang M.D. 10400 Connecticut Ave #606, Kensington, MD 20895									
	31. Date filed (Month, Day, Year) OCT 05 2000		32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32788

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>E. Patricia Finzel</b>				2. Date of Death Month Day Year <b>September 28, 2000</b>		3. Time of Death <b>10:52 am</b>																													
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Rehabilitation and Nursing Center</b>				4b. City, Town, or Location of Death <b>Burtonsville</b>		4c. County of Death <b>Montgomery</b>																													
Funeral Director	5. Social Security Number <b>219-76-4467</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Apr 10, 1908</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>																													
	Usual Residence of Decedent																																			
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																														
10e. Street and Number <b>1912 Brisbane Street</b>				10f. Zip Code <b>20902</b>		10g. Citizen of What Country? <b>USA</b>																														
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>																														
17. Father's Name (First, Middle, Last) <b>Robert John Ruge</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Frances Schreiber</b>																																
19a. Informant's Name/Relationship (Type, Print) <b>Robert P. Finzel / Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11370 Baroque Road, Silver Spring, MD 20901</b>																																
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. John's Cemetery</b>		20c. Location - City or Town, State <b>10/2/00 Silver Spring, MD</b>																														
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901</b>																																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																				
<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             a. <b>Leukemia</b>            Due to (or as a consequence of):             b. _____            Due to (or as a consequence of):             c. _____            Due to (or as a consequence of):             d. _____         </td> <td colspan="7">           23b. Did tobacco use contribute to the cause of death?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown         </td> </tr> <tr> <td colspan="7">           24a. Was an autopsy performed?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No         </td> </tr> <tr> <td colspan="7">           24b. Were autopsy findings available prior to completion of cause of death?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No         </td> </tr> <tr> <td colspan="7">           25. Was case referred to medical examiner?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No         </td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  a. <b>Leukemia</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
Immediate Cause (Final disease or condition resulting in death)  a. <b>Leukemia</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																																			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																			
<table border="1"> <tr> <td colspan="4">           Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Hypothyroidism</b> </td> <td colspan="4">           26. Place of Death (Check only one)            Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)         </td> </tr> <tr> <td colspan="4">           27. Manner of Death  <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation  <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined  <input type="checkbox"/> Homicide         </td> <td colspan="2">           28a. Date of Injury (Month, Day Year)            28b. Time of Injury            28c. Injury at Work?  <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No         </td> <td colspan="2">           28d. Describe how injury occurred            28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)            28f. Location (Street and Number or Rural Route Number, City or Town, State)         </td> </tr> </table>								Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypothyroidism</b>				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypothyroidism</b>				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																																
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<table border="1"> <tr> <td colspan="8">           29a. Certifier (Check only one)  <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated  <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.         </td> </tr> <tr> <td colspan="4">           29b. Signature and title of certifier   </td> <td colspan="2">           29c. License number  <b>D 053528</b> </td> <td colspan="2">           29d. Date signed (Month, Day, Year)  <b>September 29, 2000</b> </td> </tr> </table>								29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier 				29c. License number <b>D 053528</b>		29d. Date signed (Month, Day, Year) <b>September 29, 2000</b>														
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29b. Signature and title of certifier 				29c. License number <b>D 053528</b>		29d. Date signed (Month, Day, Year) <b>September 29, 2000</b>																														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Daphna Henkin, MD 2309 Shorefield Road, Wheaton, MD</b>																																				
31. Date filed (Month, Day, Year) <b>OCT 02 2000</b>				32. Registrar's Signature 																																

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 32789

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>Josephine V. Feury</b>		2. Date of Death Month Day Year <b>September 27, 2000</b>		3. Time of Death <b>7:15 AM</b>			
4a. Facility Name (If not institution, give street and number) <b>Potomac Valley Nursing Home</b>			4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>		
5. Social Security Number <b>090-05-5747</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b>		8. Date of Birth (Month, Day, Year) <b>August 6, 1915</b>	
9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>4830 Montgomery Lane</b>		10f. Zip Code <b>20814</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Payroll Clerk</b>		16b. Kind of Business/Industry <b>Advertising</b>		17. Father's Name (First, Middle, Last) <b>John Edward Feury</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Mary T. McGonegal</b>		19a. Informant's Name/Relationship (Type, Print) <b>Regina T. Richards/Niece</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4830 Montgomery Lane, Bethesda, Maryland 20814</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		20c. Date <b>October 2, 2000</b>		20d. Location - City or Town, State <b>Hawthorne, New York</b>		21. Signature of Funeral Service Licensee <i>Michael D. Higgins</i> M00846	
22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>		23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Respiratory Failure</b> Due to (or as a consequence of): <b>b. Pneumonia</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Merlyn K. Vemury</i>	
29c. License number <b>1 D35791</b>		29d. Date signed (Month, Day, Year) <b>September 28, 2000</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Merlyn K. Vemury, M.D., 9801 Georgia Avenue #227, Silver Spring, Maryland 20902</b>		31. Date filed (Month, Day, Year) <b>OCT 02 2000</b>	
32. Registrar's Signature <i>B. Sparks</i>		33. State Registrar <b>State Registrar</b>		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene 00 32790

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Garfield William Green, Jr.				2. Date of Death Month Day Year SEPT 28 2000		3. Time of Death 0255													
	4a. Facility Name (If not institution, give street and number) The Memorial Hospital				4b. City, Town, or Location of Death Easton		4c. County of Death Talbot													
Funeral Director	5. Social Security Number 216-40-4234		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 56	8. Date of Birth (Month, Day, Year) Aug. 31, 1944		9. Birthplace (State or Foreign Country) Maryland													
	Usual Residence of Decedent																			
To Be Completed by Funeral Director	10a. State Maryland		10b. County Talbot		10c. City, Town or Location St. Michaels		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No													
	10e. Street and Number 307 Dodson Ave.				10f. Zip Code 21663		10g. Citizen of What Country? USA													
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Crew Leader		16b. Kind of Business/Industry Public Works															
	17. Father's Name (First, Middle, Last) Garfield W. Green, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Carrie Annie Cook															
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Sharon Star Green /wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 111, St. Michaels, Maryland 21663															
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Bryran U.M. Church Cem.		20c. Location - City or Town, State 10/2/2000 Grasonville, Maryland															
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="1"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a.</td> <td>Mesenteric + peripheral ischemia</td> <td>Approximate Interval Between Onset and Death 18 hrs</td> </tr> <tr> <td>b.</td> <td>Disseminated intravascular coagulation</td> <td>7 days</td> </tr> <tr> <td>c.</td> <td>Colon Carcinoma</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Mesenteric + peripheral ischemia	Approximate Interval Between Onset and Death 18 hrs	b.	Disseminated intravascular coagulation	7 days	c.	Colon Carcinoma		d.	
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	b.	Disseminated intravascular coagulation	7 days																	
	c.	Colon Carcinoma																		
	d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																				
29b. Signature and title of certifier 				29c. License number D35887		29d. Date signed (Month, Day, Year) 9/28/00														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Smith, M.D., 29466 Pintail Dr., Easton, Maryland 21601																				
31. Date filed (Month, Day, Year) OCT 02 2000		32. Registrar's Signature 																		



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State of Maryland / Department of Health and Mental Hygiene

00 32791

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) BETTY GRUPP				2. Date of Death Month Day Year SEPT. 27, 2000		3. Time of Death 5:00 AM		
	4a. Facility Name (If not institution, give street and number) 14613 MOCKINGBIRD DRIVE				4b. City, Town, or Location of Death DARNESTOWN		4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 066-01-0741		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) MAY 26, 1912		
	9. Birthplace (State or Foreign Country) GERMANY		10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location DARNESTOWN		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 14613 MOCKINGBIRD DRIVE		10f. Zip Code 20874		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER		16b. Kind of Business/Industry OWN HOME		17. Father's Name (First, Middle, Last) MOSHE KATZ		18. Mother's Name (First, Middle, Maiden Surname) LASKA FRANKEL	
19a. Informant's Name/Relationship (Type, Print) MARION WICKER / DAUGHTER		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14613 MOCKINGBIRD DRIVE, DARNESTOWN, MD 20874		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) EDEN MEMORIAL PARK		20c. Location - City or Town, State 9/29/00 MISSION HILLS, CA	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. acute myocardial Infarction. Due to (or as a consequence of): b. Hypertension Due to (or as a consequence of): c. Pacemaker Due to (or as a consequence of): d. sick sinus syndrome		Approximate Interval Between Onset and Death			
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Vinu Ganti.		29c. License number D41162 MD		29d. Date signed (Month, Day, Year) 9/27/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VINU GANTI, MD, 19529 DOCTOR'S DRIVE, GERMANTOWN, MD 20874		31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature 					

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene 00 32792

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SAMUEL W. GREENHOUSE</b>						2. Date of Death Month Day Year <b>SEPTEMBER 29, 2000</b>			3. Time of Death <b>10:55 PM</b>			
	4a. Facility Name (If not institution, give street and number) <b>11705 MAGRUDER LANE</b>						4b. City, Town, or Location of Death <b>ROCKVILLE</b>			4c. County of Death <b>MONTGOMERY</b>			
Funeral Director	5. Social Security Number <b>050-14-5389</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>82</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>JAN 13, 1918</b>	9. Birthplace (State or Foreign Country) <b>NEW YORK</b>	
	Usual Residence of Decedent												
10a. State <b>MD</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>ROCKVILLE</b>						10d. Inside City Limits <b>1 Yes 2 No</b>			
10e. Street and Number <b>5802 NICHOLSON LANE #608</b>						10f. Zip Code <b>20852</b>			10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>			12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No WWII</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: WHITE</b>				
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) College (1-4 or 5+) 5+</b>				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>STATISTICIAN</b>				16b. Kind of Business/Industry <b>UNIVERSITY</b>					
17. Father's Name (First, Middle, Last) <b>JOSEPH GREENHOUSE</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>LENA RUBIN</b>							
19e. Informant's Name/Relationship (Type, Print) <b>RICHARD GREENHOUSE/SON</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6460 WINDERMERE CIRCLE, ROCKVILLE, MARYLAND 20852</b>							
20e. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. LEBANON CEMETERY</b>				Date <b>OCT 2, 2000</b>		20c. Location - City or Town, State <b>ADELPHI, MARYLAND</b>			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852</b>							
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ESOPHAGEAL CANCER</b>												Approximate Interval Between Onset and Death <b>ONE YEAR</b>	
23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>													
24a. Was an autopsy performed? <b>1 Yes 2 No</b>												24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>	
25. Was case referred to medical examiner? <b>1 Yes 2 No</b>												26. Place of Death (Check only one) <b>DAUGHTER'S RESIDENCE</b>	
27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>													
29b. Signature and title of certifier <b>Thomas Sacks</b>						29c. License number <b>MD12568</b>			29d. Date signed (Month, Day, Year) <b>OCTOBER 1, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. THOMAS SACKS, 2021 K STREET, NW, WASHINGTON, D.C. 20006</b>													
31. Date filed (Month, Day, Year) <b>OCT 3 2000</b>						32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 402-383-0000.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32793

Amend #23a, 10/5/2000, BMW, Montg. Co.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HENRY GREEN</b>				2. Date of Death Month Day Year <b>SEPT. 30, 2000</b>		3. Time of Death <b>1630</b>		
	4a. Facility Name (If not institution, give street and number) <b>Gladys Spellman Nursing Center</b>				4b. City, Town, or Location of Death <b>Cheverly</b>		4c. County of Death <b>PRINCE GEORGES</b>		
Funeral Director	5. Social Security Number <b>249-46-4715</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>67</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Apr. 29, 1933</b>		
	9. Birthplace (State or Foreign Country) <b>S. Carolina</b>		10a. State <b>MD</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>457 W. South Street</b>		10f. Zip Code <b>21701</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Heavy Equipment Operator</b>		16b. Kind of Business/Industry <b>Construction</b>					
17. Father's Name (First, Middle, Last) <b>Hostan Green</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hattie Keckley</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Yvette Green-Ragland (Dau.)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>457 W. South St., Frederick, MD 21701</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington Nat'l Cem</b>		20c. Date <b>10/10/00</b>		20d. Location - City or Town, State <b>Ft. Myer, VA</b>			
21. Signature of Funeral Service Licensee <i>George L. Burden</i>		22. Name and Address of Facility <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>							
23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Lung Cancer</b> Due to (or as a consequence of): <b>b. Head Tumor</b> Due to (or as a consequence of): <b>c. Intracerebral Hemorrhage</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>months</b> <b>month</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>N. S. ...</i>		29c. License number <b>541978</b>		29d. Date signed (Month, Day, Year) <b>10-2-2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>N. S. ...</b>		31. Date filed (Month, Day, Year) <b>OCT 05 2000</b>		32. Registrar's Signature <i>B. Sparks</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32794

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LILLIAN IRENE GRANT</b>				2. Date of Death Month Day Year <b>OCTOBER 3, 2000</b>		3. Time of Death <b>6:50 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>419 RUSSELL AVENUE, #214</b>				4b. City, Town, or Location of Death <b>GAITHERSBURG</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>019-10-8003</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>NOV. 25, 1920</b>		9. Birthplace (State or Foreign Country) <b>MASSACHUSETTS</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>419 Russell Avenue #214</b>				10f. Zip Code <b>20877</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Intelligence Officer CIA</b>			16b. Kind of Business/Industry <b>Federal Government</b>	
17. Father's Name (First, Middle, Last) <b>Levi Grant</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Irene Gardiner Copp</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Betty Stevens (Friend)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>419 Russell Avenue #214, Gaithersburg, MD 20877</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		Data <b>10/3/00</b>		20c. Location - City or Town, State <b>Alexandria, Virginia</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>PANCREATIC CANCER</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>1 MONTH</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CEREBROVASCULAR DISEASE</b> <b>ATRIAL FIBRILLATION</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier  <b>JOHN R. MELNICK, M.D.</b>				29c. License number <b>D19294</b>		29d. Date signed (Month, Day, Year) <b>OCTOBER 3, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JOHN R. MELNICK, M.D., 911 RUSSELL AVENUE, GAITHERSBURG, MD 20879</b>								
31. Date filed (Month, Day, Year) <b>OCT 04 2000</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

15

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32795

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Howard L. Grant				2. Date of Death Month Day Year September 27, 2000				3. Time of Death 4:02pm	
	4e. Facility Name (If not institution, give street and number) Mariner Health of Bethesda				4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 053-18-9883		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) May 4, 1925		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 6704 Renita Lane				10f. Zip Code 20817		10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Army If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Merchant				16b. Kind of Business/Industry Dictograph Security Systems			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Charles Lepcofker				18. Mother's Name (First, Middle, Maiden Surname) Frieda Henshaw					
	19e. Informant's Name/Relationship (Type, Print) Mickey J. Grant / Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6704 Renita Lane, Bethesda, MD 20817					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) King David Memorial Gardens			20c. Location - City or Town, State Falls Church, VA				
	21. Signature of Funeral Service Licensee Donald C. Stottmeyer		22. Name and Address of Facility Danzansky Goldberg Memorial Chapel, Inc. 1170 Rockville Pike, Rockville, MD 20852							
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death)								9 months	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								3 weeks	
	Due to (or as a consequence of): Prostate Cancer with Metastasis Pneumonia									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive lung disease								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
									24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
State Registrar	29b. Signature and title of certifier R. Tuli				29c. License number D19609		29d. Date signed (Month, Day, Year) September 28, 2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raman R. Tuli, M. D. 10810 Darnestown Road, # 202, Gaithersburg, Maryland 20878									
State Registrar	31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature B. Sparks							





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State of Maryland / Department of Health and Mental Hygiene

00 32796

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ralph Roger Goodwin</b>				2. Date of Death Month <b>September</b> Day <b>27</b> , Year <b>2000</b>		3. Time of Death <b>7:30 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>101 Oxford Street</b>				4b. City, Town, or Location of Death <b>Chevy Chase</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>109-26-9915</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 24, 1917</b>		9. Birthplace (State or Foreign Country) <b>Massachusetts</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Chevy Chase</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>101 Oxford Street</b>				10f. Zip Code <b>20815</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Historical Researcher</b>		16b. Kind of Business/Industry <b>United States Department of State</b>				
	17. Father's Name (First, Middle, Last) <b>Thomas Aubrey Goodwin</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sadie Estelle Tenney</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Henry Miller/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>101 Oxford Street, Chevy Chase, Maryland 20815</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		Date <b>September 28, 2000</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>		
	21. Signature of Funeral Service Licensee <i>Michael E. Higgins</i> M00846		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>						
	23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pneumonia</b> Due to (or as a consequence of): <b>b. Myelodysplasia</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Heart Disease</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Thomas C. Havell</i>				29c. License number <b>DC6104</b>		29d. Date signed (Month, Day, Year) <b>September 28, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Thomas C. Havell, II, M.D., 4201 Cathedral Avenue, NW, Washington, D.C. 20016-4901</b>									
State Registrar		31. Date filed (Month, Day, Year) <b>OCT 02 2000</b>		32. Registrar's Signature <i>B. Sparks</i>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32797

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWARD GOLFER				2. Date of Death Month Day Year SEPT. 29 2000				3. Time of Death 6:45 PM		
	4a. Facility Name (If not institution, give street and number) SUBURBAN HOSPITAL				4b. City, Town, or Location of Death BETHESDA				4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 577-40-0087		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) APRIL 16 1921		9. Birthplace (State or Foreign Country) GERMANY		
	Usual Residence of Decedent				10e. State MD		10b. County MONTGOMERY		10c. City, Town or Location BETHESDA		
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number 8717 EWING DR.				10f. Zip Code 20817		
	10g. Citizen of What Country? U.S.A.				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) GROCER				16b. Kind of Business/Industry SELF-EMPLOYED				17. Father's Name (First, Middle, Last) ABRAHAM LEB		
	18. Mother's Name (First, Middle, Maiden Surname) HANNAH (UNOBTAINABLE)				19a. Informant's Name/Relationship (Type, Print) J. LARRY GOLFER/ SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3345 SHEFFIELD CT. FALLS CHURCH, VA 22042		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) JUDEAN MEMORIAL GARDENS				20c. Location - City or Town, State 10/3/2000 OLNEY, MD		
	21. Signature of Funeral Service Licensee				22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. CARDIO PULMONARY ARREST Due to (or as a consequence of): b. RESPIRATORY FAILURE Due to (or as a consequence of): c. PNEUMONIA Due to (or as a consequence of): d.		
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M				28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier				29c. License number 00052774		
	29d. Date signed (Month, Day, Year) 9/29/00				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEO C. ROTUNDO MD. - SUBURBAN HOSPITAL, BETHESDA MD				31. Date filed (Month, Day, Year) OCT 02 2000		
32. Registrar's Signature B. Sparks											

2020-01-10 12:10:10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32798

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Patrick F. Gilbo				2. Date of Death Month Day Year September 26, 2000				3. Time of Death 3:00PM	
	4a. Facility Name (If not Institution, give street and number) Montgomery Hospice Casey House				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 379-34-5440		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 6, 1937		9. Birthplace (State or Foreign Country) Michigan	
	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number 206 Pender Place				10f. Zip Code 20850		10g. Citizen of What Country? United States			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1954-1958		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Historian		16b. Kind of Business/Industry American Red Cross			
	17. Father's Name (First, Middle, Last) Francis Joseph Gilbo				18. Mother's Name (First, Middle, Maiden Surname) Florence Derowski					
	19a. Informant's Name/Relationship (Type, Print) Rosalind F. Gordon-Gilbo/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Pender Place, Rockville, Maryland 20850					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Quantico Nat'l Cemetery		Date Oct 2 2000		20c. Location - City or Town, State Triangle, Virginia			
	21. Signature of Funeral Service Licensee Doris E. Perry M00803				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				a. Transitional Cell Carcinoma of Bladder Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.				Approximate Interval Between Onset and Death 2 Years	
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier		29c. License number D0054378		29d. Date signed (Month, Day, Year) September 26, 2000			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cheryl Aylesworth, M.D. 6800 Georgia Avenue, N.W., Washington, D.C. 20807				31. Date filed (Month, Day, Year) OCT 02 2000				32. Registrar's Signature B. Sparks	

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 32799

Amend #29d, 10/4/2000, BMW, Montg. Co.

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kareemeh N. Gharfeh

2. Date of Death

October 2, 2000

3. Time of Death

2:08 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

579-82-3004

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Nov 23, 1929

9. Birthplace (State or Foreign Country)

Palestine

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12006 Terra Lane

10f. Zip Code

20715

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jiriyis Tawasha

18. Mother's Name (First, Middle, Maiden Surname)

Fareeda G. Dugman

19a. Informant's Name/Relationship (Type, Print)

Nicola Gharfeh/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12006 Terra Lane, Bowie, MD 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery 10/5/00

Date

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

J. Ken Skile

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Sepsis

Approximate  
Interval Between  
Onset and Death

days

Due to (or as a consequence of):

b. End stage renal disease

years

Due to (or as a consequence of):

c. Diabetes mellitus

years

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

(L) Foot ulcer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

J. Ken Skile MD

29c. License number

D 53411

29d. Date signed (Month, Day, Year)

October 3rd 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3060 mitchellville Rd # 103 Bowie MD 20715

Dr. Jagdish Shesadria

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 04 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitBaltimore, Maryland 21215-0020  
To Be Completed by Funeral Director  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

3

Kareemeh Nicola Gharfeh



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

32800

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Edward Genies

2. Date of Death

September 29, 2000

3. Time of Death

11:40 PM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

215-58-9263

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 18, 1951

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Montgomery Village

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9483 Chadburn Place

10f. Zip Code

20886

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Contractor

16b. Kind of Business/Industry

Warehouse

17. Father's Name (First, Middle, Last)

Ernest Hackey

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Genies

19a. Informant's Name/Relationship (Type, Print)

Nancy A. Genies/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9483 Chadburn Place, Montgomery Village, MD. 20886

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

10/4/00 Silver Spring, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr., Gaithersburg, MD. 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 WEEKS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NON SMALL CELL LUNG CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 42452

29d. Date signed (Month, Day, Year)

SEPTEMBER 30, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. CHITRA KAJAGOPAL, M.D.  
18111, PRINCE PHILIP DRIVE, #327, OLNEY, MARYLAND 20832State  
Registrar

31. Date filed (Month, Day, Year)

OCT 04 2000

32. Registrar's Signature

James B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 32a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32801

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Georgia Lee Ganas				2. Date of Death Month Day Year October 1, 2000				3. Time of Death 7:05 P.M.		
	4a. Facility Name (If not institution, give street and number) Casey House				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 577-48-7368		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) September 5, 1934		9. Birthplace (State or Foreign Country) Kentucky		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Germantown				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 19042 Cherry Bend Drive				10f. Zip Code 20874		10g. Citizen of What Country? United States					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Editor				16b. Kind of Business/Industry Newspaper			
17. Father's Name (First, Middle, Last) George Washington Hall				18. Mother's Name (First, Middle, Maiden Surname) Victoria Norton							
19a. Informant's Name/Relationship (Type, Print) Cassandra Barbour/ Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5703 Seaside Walk, Long Beach, CA 90803							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Geo. Wash. University Medical Center		Date October 1 2000		20c. Location - City or Town, State Washington, D.C.					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Metastatic Carcinoma Due to (or as a consequence of): b. Squamous Cell- Unknown Primary Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 11 Months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 				29c. License number D09470		29d. Date signed (Month, Day, Year) October 3, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene P. Libre, M.D. 10400 Connecticut Avenue, Kensington, MD 20895											
31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature 									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene  
 amend item 10a,b,c,e,f 11 per informant G/89 11/29/00 yr  
 Certificate of Death 00 32802  
 Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ethel Gamer</b>				2. Date of Death Month Day Year <b>Sept. 28, 2000</b>				3. Time of Death <b>8:50P.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Hebrew Home of Greater Washington</b>				4b. City, Town, or Location of Death <b>Rockville</b>				4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>578-50-0673</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 22, 1908</b>		9. Birthplace (State or Foreign Country) <b>New York</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Montgomery County</b>		10c. City, Town or Location <b>Washington, D.C.</b> <b>Rockville</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>3512 Rittenhouse St., N.W.</b>				10f. Zip Code <b>20015</b> <b>20502</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			16b. Kind of Business/Industry <b>own home</b>		
	17. Father's Name (First, Middle, Last) <b>Jacob Huchberger</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude Oppeheim</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Janet Perlman (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Washington Hebrew Cemetery</b>			20c. Location - City or Town, State <b>10/2/2000 Washington, D.C.</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A.</b> <b>4400 Powder Mill Rd. Beltsville, Maryland 20705</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Cerebral Thrombosis</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>TYPE I Diabetes mellitus</b> <b>Dementia, vascular</b>									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number <b>D18084</b>		29d. Date signed (Month, Day, Year) <b>SEPTEMBER 29 2000</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>D.D. PATEL, M.D. 6121 Montrose Rd, Rockville, MD 20852</b>									
	31. Date filed (Month, Day, Year) <b>OCT 03 2000</b>		32. Registrar's Signature 							

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32803

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY G. CUMMINS

2. Date of Death

Month

Day

Year

3. Time of Death

Oct 12 2000 2:20 AM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

HOWARD COUNTY GENERAL HOSPITAL COLUMBIA

4b. City, Town, or Location of Death

4c. County of Death

HOWARD

5. Social Security Number

213 26 4702

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 25, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Elkridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6734 Montgomery Road

10f. Zip Code

21075

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Payroll Clerk

16b. Kind of Business/Industry

State Government

17. Father's Name (First, Middle, Last)

Charles H. Detzel

18. Mother's Name (First, Middle, Maiden Surname)

Mary V. MacDonaldson

19a. Informant's Name/Relationship (Type, Print)

Ronald J. Cummins/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6734 Montgomery Road Elkridge, MD 21075

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

10-13-2000 Catonsville, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Sharon A. Gellis - Witzke

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.  
4112 Old Columbia Pike Ellicott City, MD 21043

23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic lung carcinoma,  
chronic obstructive pulmonary  
disease, atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD, FCCP

29c. License number

D 36845

29d. Date signed (Month, Day, Year)

Oct 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAI-CHI NGUYEN, MD, FCCP  
7350 Grace Drive, Columbia, MD 21044State  
Registrar

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

Dennis B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 32804

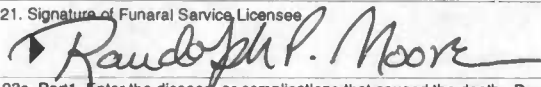
Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>Grace Belle Greeley</b>				2. Date of Death Month <b>September</b> Day <b>25</b> Year <b>2000</b>		3. Time of Death <b>1:50AM</b>	
4a. Facility Name (If not Institution, give street and number) <b>Caroline Nursing Home, Inc.</b>				4b. City, Town, or Location of Death <b>Denton</b>		4c. County of Death <b>Caroline</b>	
5. Social Security Number <b>004-10-0234</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>93</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 7, 1907</b>	
9. Birthplace (State or Foreign Country) <b>Maine</b>							

Funeral  
Director

To Be Completed by Funeral Director

10e. State <b>Maryland</b>		10b. County <b>Caroline</b>		10c. City, Town or Location <b>Marydel</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>27150 Stafford Road</b>				10f. Zip Code <b>21649</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Caucasian</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Medical Homemaker/Technologist</b>		16b. Kind of Business/Industry <b>Pathology Home/ Medicine</b>	
17. Father's Name (First, Middle, Last) <b>Harry Ashton Spaulding</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jessie Elizabeth Baker</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Andrea S. Norris Niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3017 Riverview Road, Lawrence, Kansas 66049</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Capitol Crematory</b>		Date <b>9/26/00</b>		20c. Location - City or Town, State <b>Dover, Delaware</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629</b>			

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)		a. <b>Pneumonia</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>1 month</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <b>Aspiration</b> Due to (or as a consequence of):		
		c. <b>Alzheimer's Disease</b> Due to (or as a consequence of):		
		d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

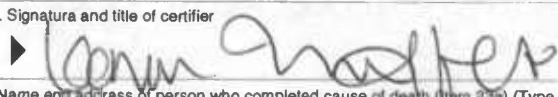
23b. Did tobacco use contribute to the cause of death?  
☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?  
☐ Yes ☒ No

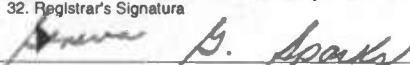
24b. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☒ No

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b>	
		28b. Time of Injury <b>1</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		28d. Describe how injury occurred	
		28e. Location (Street and Number or Rural Route Number, City or Town, State)	

29a. Certifier (Check only one)  
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

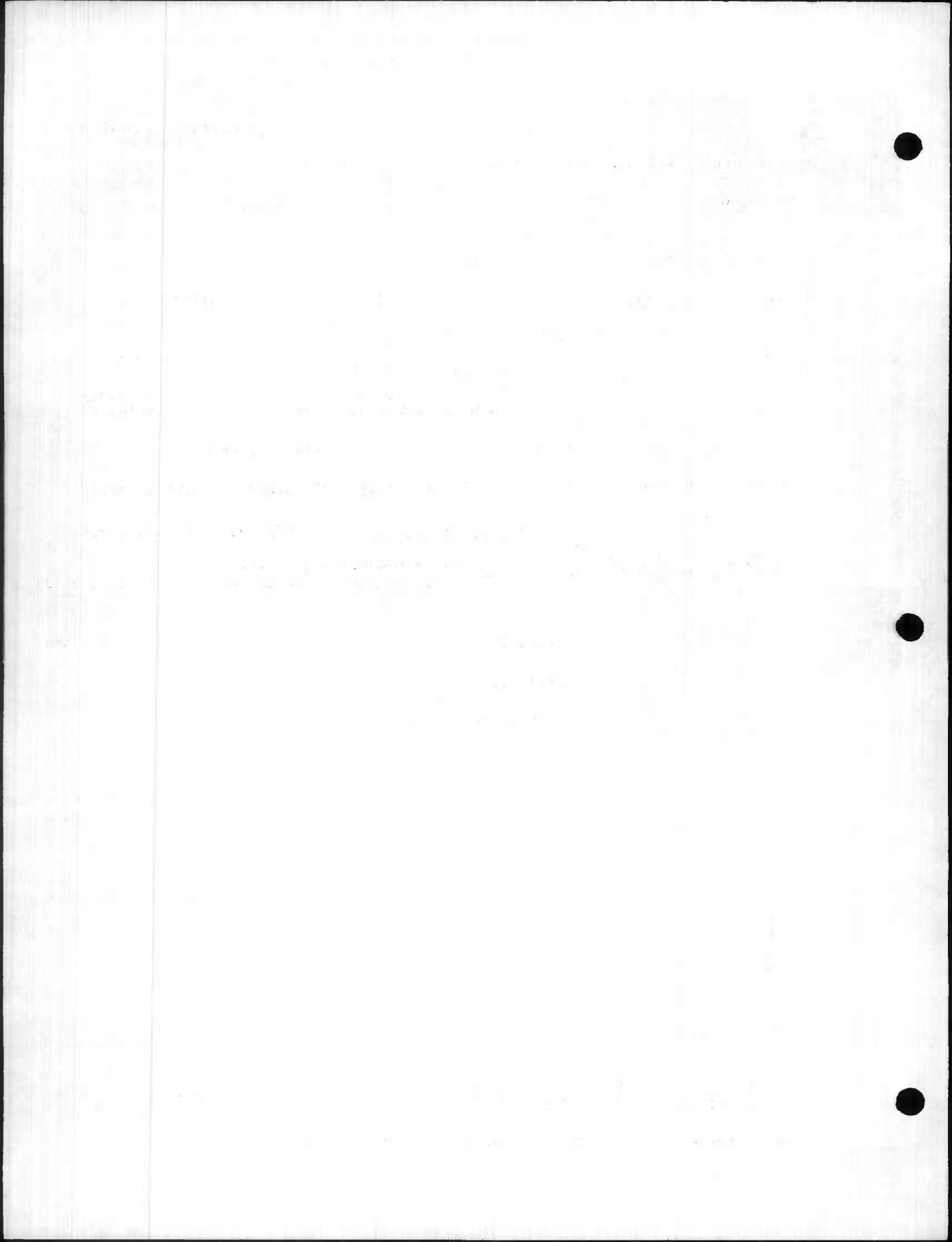
29b. Signature and title of certifier 		29c. License number <b>D51639</b>		29d. Date signed (Month, Day, Year) <b>9-25-00</b>	
--	--	--------------------------------------	--	---	--

30. Name and address of person who completed cause of death (Form 23a) (Type, Print)  
**Karen Moffett, M.D., Daffin Lane, Denton, Maryland 21629**

31. Date filed (Month, Day, Year) <b>SEP 27 2000</b>		32. Registrar's Signature 	
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Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: 26 PER PHY G787 10-16-00 <sup>WR</sup> Certificate of Death

Reg. No.

00 32805

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ROBERTA ELIZABETH GATES					2. Date of Death Month Day Year SEPTEMBER 19 2000		3. Time of Death 8:38 PM		
	4a. Facility Name (If not Institution, give street and number) 13909 BLACK VALLEY ROAD					4b. City, Town, or Location of Death FLINTSTONE		4c. County of Death ALLEGANY		
Funeral Director	5. Social Security Number 220-28-9290		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN 30 1931		9. Birthplace (State or Foreign Country) W. VA.	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ALLEGANY		10c. City, Town or Location CUMBERLAND			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	10e. Street and Number 308 MAGRUDER STREET				10f. Zip Code 21502		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOME MAKER			16b. Kind of Business/Industry HOME MAKER			
	17. Father's Name (First, Middle, Last) HARRY EMMITT SANFORD WALKER					18. Mother's Name (First, Middle, Maiden Surname) SARAH CATHERINE WILLIS				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) STEPHANIE R. GATES DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13909 BLACK VALLEY ROAD FLINTSTONE MARYLAND 21530					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) SUNSET CEMETERY		Date SEPT 23 2000		20c. Location - City or Town, State CUMBERLAND MARYLAND			
	21. Signature of Funeral Service Licensee <i>Dale L. Merritt</i>				22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOME P.A. 404 DECATUR STREET CUMBERLAND MARYLAND					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. <u>Pancreatic Cancer</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death 6 month	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Hypertension, DM, CAD, Peripheral Vascular</u>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>Daughter's Home</u>								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <i>Dr. Huma Shakil MD</i>					29c. License number D 46346		29d. Date signed (Month, Day, Year) SEPTEMBER 20 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR HUMA SHAKIL 625 KENT AVE. CUMBERLAND MARYLAND 21502										
31. Date filed (Month, Day, Year) SEP 21 2000					32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

State  
Registrar

Sept 8 - 1932

000 10932

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32806

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EDWARD BRENNEMAN HENRY</b>				2. Date of Death Month Day Year <b>SEPT. 30 2000</b>		3. Time of Death <b>5:30 AM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>10710 OCEAN GATEWAY</b>				4b. City, Town, or Location of Death <b>EASTON</b>		4c. County of Death <b>TALBOT</b>	
Funeral Director	5. Social Security Number <b>217-28-2852</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>AUG. 14, 1931</b>	
	9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>		10a. State <b>MD</b>		10b. County <b>TALBOT</b>		10c. City, Town or Location <b>EASTON</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>10710 OCEAN GATEWAY</b>		10f. Zip Code <b>21601</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1950-54</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MACHINIST</b>		16b. Kind of Business/Industry <b>TRAILOR FABRICATION</b>			
	17. Father's Name (First, Middle, Last) <b>JAMES EDWARD HENRY, SR.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY CARMEN BRENNEMAN</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>EMILY T. HENRY/WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10710 OCEAN GATEWAY, EASTON, MD 21601</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>ST. PAUL'S CEMETERY</b>		20c. Location - City or Town, State <b>CORDOVA, MD</b>		20d. Date <b>10/4/2000</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>M. E. Newnam</b>				22. Name and Address of Facility <b>FELLOWS, HELFENBEIN, &amp; NEWNAM FUNERAL HOME, 200 S. HARRISON STREET, EASTON, MD 21601</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Melanoma</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death <b>24-48</b>
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <b>David Smith</b>				29c. License number <b>D39887</b>		29d. Date signed (Month, Day, Year) <b>10/2/00</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAVID H. SMITH, M.D., 29466 PINTAIL DRIVE, EASTON, MD 21601</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>OCT 03 2000</b>				32. Registrar's Signature <b>B. Sparks</b>			

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 32807

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William D. Howell				2. Date of Death Month Day Year September 27, 2000				3. Time of Death 4:00 P.M.	
	4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				4b. City, Town, or Location of Death Takoma Park				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-03-7395	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 10, 1911		9. Birthplace (State or Foreign Country) Missouri		
	Usual Residence of Decedent									
10a. State Virginia		10b. County Fairfax		10c. City, Town or Location Falls Church				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 3013 Westcott Street				10f. Zip Code 22042		10g. Citizen of What Country? USA				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1940-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Researcher		16b. Kind of Business/Industry National Archives				
17. Father's Name (First, Middle, Last) James E. Howell				18. Mother's Name (First, Middle, Maiden Surname) Myrtra Mae McCulloch						
19a. Informant's Name/Relationship (Type, Print) James Howell/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11416 Indigo Drive, Beltsville, Maryland 20705						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Northern VA Funeral Svcs.		Data Sept. 29, 2000		20c. Location - City or Town, State Chantilly, Virginia				
21. Signature of Funeral Service Licensee <i>Shirley Harman</i>				22. Name and Address of Facility Northern Virginia Funeral Services 14522L Lee Road, Chantilly, Virginia 20151						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				a. Acute Respiratory Failure Due to (or as a consequence of): b. Pseudomonas pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28t. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>W. Mathur</i>				29c. License number D 42403		29d. Date signed (Month, Day, Year) 9-27-2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJ MATHUR 106 INDIAN ST. WASHINGTON DC 20010										
31. Date filed (Month, Day, Year) OCT 02 2000		32. Registrar's Signature <i>B. Sparks</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene

00 32808

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ERNESTINE RICKS HOWELL</b>				2. Date of Death Month Day Year <b>SEPT. 30, 2000</b>		3. Time of Death <b>5:15 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Mariner Health of Kensington</b>				4b. City, Town, or Location of Death <b>Kensington</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>578-07-0144</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 27, 1910</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>N/A</b>		10b. County <b>Washington, DC</b>		10c. City, Town or Location <b>Washington, DC</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>5721 6th Street, NW</b>		10f. Zip Code <b>20011</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (14 or 5+) <b>College</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Dental Assistant</b>		16b. Kind of Business/Industry <b>Dental Services</b>				
17. Father's Name (First, Middle, Last) <b>Ernest Ricks</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Emma Green</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Joyce Ricks Dennis (Niece)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5721 6th Street, NW, Washington, DC 20011</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Pleasant View Cem.</b>		20c. Location - City or Town, State <b>10/5/00 Gaithersburg, MD</b>				
21. Signature of Funeral Service Licensee <i>George R. Snowden</i>				22. Name and Address of Facility <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Renal failure</i> Due to (or as a consequence of): b. <i>Atherosclerotic cardiovascular disease</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Approximate Interval Between Onset and Death <i>2 yrs.</i>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>dementia</i> <i>hypothyroidism</i>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>P00053528</b>		29d. Date signed (Month, Day, Year) <b>October 3, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John Hendin, MD 2309 Sherrifield Road Wheaton, MD</b>								
31. Date filed (Month, Day, Year) <b>OCT 05 2000</b>				32. Registrar's Signature <i>[Signature]</i>				

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32809

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BLACKWELL O'BRIAN HOLMES</b>						2. Date of Death Month Day Year <b>SEP 29 2000</b>		3. Time of Death <b>2:50 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>						4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>231-09-2743</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct 7, 1921</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>			10b. County <b>Montgomery</b>			10c. City, Town or Location <b>Silver Spring</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>710 North Belgrade Court</b>			10f. Zip Code <b>20902</b>			10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates: <b>Korean War</b>			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor of Security</b>			16b. Kind of Business/Industry <b>Johns Hopkins APL</b>				
17. Father's Name (First, Middle, Last) <b>Riddick Holmes</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Eliza O'Brian</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Eunice Holmes / Wife</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>710 North Belgrade Court, Silver Spring, MD 20902</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>			20c. Location - City or Town, State <b>9/30/00 Alexandria, VA</b>				
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901</b>				
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>a. PNEUMONIA</b> Due to (or as a consequence of):										
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of):										
<b>c.</b> Due to (or as a consequence of):										
<b>d.</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 			29c. License number <b>20-A-7245 (CA)</b>			29d. Date signed (Month, Day, Year) <b>9/29/00</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>M.M. PERELLO, LT, MC, USNR</b>						<b>NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600</b>				
31. Date filed (Month, Day, Year) <b>OCT 2 2000</b>			32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32810

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

TERENCE JOSEPH HERRON

2. Date of Death

Month Day Year

SEPTEMBER 30, 2000 10:20 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

National Institute of Health

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

213-56-2311

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 22, 1950

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1811 Belvedere Boulevard

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Budget Analyst

16b. Kind of Business/Industry

National Institute  
of Health

17. Father's Name (First, Middle, Last)

John M. Herron

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Ellen McAndrew

19a. Informant's Name/Relationship (Type, Print)

Patricia Ann Herron / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1811 Belvedere Boulevard, Silver Spring, MD 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

10/4/00

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. MULTI-SYSTEM ORGAN FAILURE

2 weeks

Due to (or as a consequence of):

f. SEPTIC SHOCK

Due to (or as a consequence of):

g. SEVERE SKIN GRAFT VERSUS HOST DISEASE

Due to (or as a consequence of):

h. METASTATIC RENAL CELL CARCINOMA

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

181-9617

29d. Date signed (Month, Day, Year)

10/01/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SAMEENA KHAN, M.D.

9000 ROCKVILLE PIKE BETHESDA, MARYLAND 20892

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 02 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

*[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]*



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32811

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary J. Hawley				2. Date of Death Month Day Year October 3, 2000		3. Time of Death 10:00 AM										
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery										
Funeral Director	5. Social Security Number 384-20-6945	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) October 10, 1926		9. Birthplace (State or Foreign Country) Michigan									
	Usual Residence of Decedent																
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Potomac		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
	10e. Street and Number 8817 Cold Spring Road				10f. Zip Code 20854		10g. Citizen of What Country? United States										
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Social Worker		16b. Kind of Business/Industry State of Michigan												
	17. Father's Name (First, Middle, Last) Emilio Morelli				18. Mother's Name (First, Middle, Maiden Surname) Anna Zimei												
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Margaret L. Hawley/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4821 Drummond Avenue, Chevy Chase, Maryland 20815												
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) St. Mary's Cemetery		Date October 6, 2000		20c. Location - City or Town, State Rockville, Maryland										
	21. Signature of Funeral Service Licensee <i>Michael S. Higgins</i> M00846		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805														
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>Metastatic Lung Cancer</td> <td rowspan="4">Approximate interval Between Onset and Death 17 yrs</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Metastatic Lung Cancer	Approximate interval Between Onset and Death 17 yrs	b.	Due to (or as a consequence of):	c.	Due to (or as a consequence of):	d.
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	Metastatic Lung Cancer	Approximate interval Between Onset and Death 17 yrs														
	b.	Due to (or as a consequence of):															
	c.	Due to (or as a consequence of):															
	d.	Due to (or as a consequence of):															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown											
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No											
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)											
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. Signature and title of certifier <i>Frederick P. Smith</i>				29c. License number D33293		29d. Date signed (Month, Day, Year) 10.3.00											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick P. Smith, M.D., 5401 Western Avenue, NW, Washington, DC 20015-2998																	
31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature <i>B. Sparks</i>															

11/1

Handwritten signature

1000

Handwritten signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32812

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Garmon, Hawkins</u>				2. Date of Death Month <u>October</u> Day <u>one</u> Year <u>2000</u>				3. Time of Death <u>4:07 pm</u>		
	4a. Facility Name (If not institution, give street and number) <u>University of Maryland Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore City</u>				4c. County of Death <u>Baltimore City</u>		
Funeral Director	5. Social Security Number <u>241-09-7613</u>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>93</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>January 15, 1907</u>		9. Birthplace (State or Foreign Country) <u>North Carolina</u>		
	Usual Residence of Decedent				10a. State <u>MD</u>				10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>
10a. Street and Number <u>1601 E. Belvedere Ave</u>				10f. Zip Code <u>21239</u>				10g. Citizen of What Country? <u>United States</u>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>4</u> College (1-4 or 5+) <u>4</u>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Used Car Dealer</u>				16b. Kind of Business/Industry <u>Whitlock Motors</u>			
17. Father's Name (First, Middle, Last) <u>John Benjamin Hawkins</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Florence Elizabeth Dellinger</u>							
19a. Informant's Name/Relationship (Type, Print) <u>Judith L. Mehrling / daughter</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5126 Hillburn Ave Baltimore, MD 21206</u>							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Chesapeake Crematory, Inc.</u>		Date <u>10/6/00</u>		20c. Location - City or Town, State <u>Beltsville, MD</u>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <u>CAFA Stephen D. LOhrmann, P.A.</u> <u>8717 Green Pastures Dr., Towson, MD 21286</u>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)											
a. <u>pneumonia</u> Due to (or as a consequence of):											
b. <u>urosepsis</u> Due to (or as a consequence of):											
c. Due to (or as a consequence of):											
d. Due to (or as a consequence of):											
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 				29c. License number <u>P12434</u>				29d. Date signed (Month, Day, Year) <u>October one, 2000</u>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Mysheika Lemonte-Williams, MD</u> <u>2231 Greene Street Baltimore, Maryland 21207</u>											
31. Date filed (Month, Day, Year) <u>OCT 05 2000</u>				32. Registrar's Signature 							

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32813

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Maynard C. Happe</u>				2. Date of Death Month <u>10</u> Day <u>03</u> Year <u>2000</u>		3. Time of Death <u>4:20</u>			
	4a. Facility Name (If not institution, give street and number) <u>Montgomery General Hospital</u>				4b. City, Town, or Location of Death <u>Olney, MD</u>		4c. County of Death <u>Montgomery</u>			
Funeral Director	5. Social Security Number <u>471 01 4913</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>90</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>MARCH 20, 1910</u>			
	9. Birthplace (State or Foreign Country) <u>WISCONSIN</u>		10a. State <u>MD</u>		10b. County <u>MONTGOMERY</u>		10c. City, Town or Location <u>SILVER SPRING</u>			
Usual Residence of Decedent										
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			10e. Street and Number <u>3576 GLENN EAGLES DRIVE</u>			10f. Zip Code <u>20906</u>		10g. Citizen of What Country? <u>USA</u>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u>			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>SHEET METAL WORKER</u>			16b. Kind of Business/Industry <u>MALTING</u>				
17. Father's Name (First, Middle, Last) <u>EDWARD HAPPE</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>KATE BOLLAND</u>			19a. Informant's Name/Relationship (Type, Print) <u>MILDRED HAPPE (SPOUSE)</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3576 GLENN EAGLES DRIVE SILVER SPRING, MD 20906</u>	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>FORT LINCOLN CREMATORY</u>			20c. Date <u>10-5-00</u>		20d. Location - City or Town, State <u>BRENTWOOD, MARYLAND</u>		
21. Signature of Funeral Service Licensee <u>[Signature]</u>			22. Name and Address of Facility <u>MINES-RINALDI 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904</u>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) e. <u>Sepsis</u> Due to (or as a consequence of):									<u>1 wk</u>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. <u>Pneumonia</u> Due to (or as a consequence of):									<u>2 wk</u>	
c. <u>Ischemic Colitis</u> Due to (or as a consequence of):									<u>2 wks</u>	
d.										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CVA</u>									23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									29b. Signature and title of certifier <u>[Signature]</u>	
29c. License number <u>D50926</u>			29d. Date signed (Month, Day, Year) <u>10/3/2000</u>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Pamela Wright, M.D.</u> <u>2715 Medical Center Drive, Rockville, MD 20850</u>										
31. Date filed (Month, Day, Year) <u>OCT 05 2000</u>			32. Registrar's Signature <u>[Signature]</u>							

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6





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State of Maryland / Department of Health and Mental Hygiene

00 32814

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Robert January		2. Date of Death Month Day Year Oct. 2, 2000		3. Time of Death 3:57 AM
	4a. Facility Name (If not institution, give street and number) Manor Care Largo		4b. City, Town, or Location of Death Largo		4c. County of Death Prince Georges
Funeral Director	5. Social Security Number 436-10-9620	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	8. Date of Birth (Month, Day, Year) Nov. 28, 1914	9. Birthplace (State or Foreign Country) Louisiana
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State N/A	10b. County N/A	10c. City, Town or Location Washington, D.C.		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 3298 Fort Lincoln Drive		10f. Zip Code 20018		10g. Citizen of What Country? United States
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collegia (1-4or 5+)		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cab Driver		16b. Kind of Business/Industry Transportation		
	17. Father's Name (First, Middle, Last) Eugene Williams		18. Mother's Name (First, Middle, Maiden Surname) unknown		
	19a. Informant's Name/Relationship (Type, Print) Gwendolyn L. Thomas - Cousin		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3902 Daphne, Houston, Texas 77021		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Cemetery		20c. Location - City or Town, State 10/6/00 Suitland, Maryland
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee Andrie Thompson		22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	Immediate Cause (Final disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease years Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cancerous Esophagus				
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
State Registrar	29b. Signature and title of certifier Paul A. DeVore, M.D.		29c. License number D01852		29d. Date signed (Month, Day, Year) October 3, 2000
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Paul A. DeVore, M.D. 4203 Queensbury Road, Hyattsville, Maryland 20781				
State Registrar	31. Date filed (Month, Day, Year) OCT 06 2000		32. Registrar's Signature B. Sparks		

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 32815

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Minnie E. Kuzemka				2. Date of Death Month Day Year Sept 29, 2000				3. Time of Death 3:30 PM		
	4a. Facility Name (If not institution, give street and number) 706 Notley Rd				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 236-28-9255		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		8. Date of Birth (Month, Day, Year) May 13, 1923		9. Birthplace (State or Foreign Country) West Virginia		
	Usual Residence of Decedent				10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 706 Notley Rd		10f. Zip Code 20904		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry Department of Agriculture				
	17. Father's Name (First, Middle, Last) Erminio Mariotti				18. Mother's Name (First, Middle, Maiden Surname) Natalina Polica						
	19a. Informant's Name/Relationship (Type, Print) Alex W. Kuzemka/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 Notley Rd, Silver Spring, MD 20904						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		Date Oct 2		20c. Location - City or Town, State Silver Spring, MD				
	21. Signature of Funeral Service Licensee ▶ Alan J. Donnell				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Urosepsis Due to (or as a consequence of): b. Multiple Sclerosis Due to (or as a consequence of): c. Due to (or as a consequence of): d. Approximate Interval Between Onset and Death 14 days 21 years										
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
					24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier ▶ Adeline MD				29c. License number D22755		29d. Date signed (Month, Day, Year) Sept. 30, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Christine Delima, MD 7350 Van Dusen Road #260 Laurel, MD 20707				31. Date filed (Month, Day, Year) Oct 6 2 2000				32. Registrar's Signature Geneva B. Sparks			

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene 00 32816

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Clevie L. Kohl</b>				2. Date of Death Month <b>September</b> Day <b>26</b> Year <b>2000</b>		3. Time of Death <b>7:05AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Randolph Hills Nursing Home</b>				4b. City, Town, or Location of Death <b>Wheaton</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>218-22-6622</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 25, 1919</b>		
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Wheaton</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	10e. Street and Number <b>4011 Randolph Road</b>				10f. Zip Code <b>20902</b>		10g. Citizen of What Country? <b>United States</b>		
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>William Baxter</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Nellie Baxter</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Mary E. Egnor/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14724 Algretus Drive, Centreville, Virginia 20120</b>				
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		Date <b>October 1, 2000</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>		
	21. Signature of Funeral Service Licensee  <b>M00198</b>		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.</b> <b>7557 Wisconsin Avenue</b> <b>Bethesda, Maryland 20814-3501</b>						
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Septicemia</b> Due to (or as a consequence of):  b. <b>Gangrene</b> Due to (or as a consequence of):  c. <b>Peripheral Arterial Insufficiency</b> Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death  <b>1 month</b>  <b>months</b>  <b>years</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Atrial Filbrillation, Asthma, Dementia</b>  <b>Multiple Decubiti</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D08944</b>		29d. Date signed (Month, Day, Year) <b>September 26, 2000</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Martin C. Shargel, M.D. 3720 Farragut Avenue, Kensington, Maryland 20895</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>OCT 6 2 2000</b>		32. Registrar's Signature 						

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 32817

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EDWARD KLINGER						2. Date of Death Month Day Year SEPT. 30 2000		3. Time of Death 6:05 PM																	
	4a. Facility Name (If not institution, give street and number) 257 CONGRESSIONAL LANE						4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY																	
Funeral Director	5. Social Security Number 127-32-7235		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) SEPT. 7 1906		9. Birthplace (State or Foreign Country) POLAND																	
	Usual Residence of Decedent																									
10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location ROCKVILLE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
10e. Street and Number 257 CONGRESSIONAL LANE						10f. Zip Code 20852		10g. Citizen of What Country? U.S.A.																		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE																		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) GROCER				16b. Kind of Business/Industry SELF-EMPLOYED																		
17. Father's Name (First, Middle, Last) MEYER KLINGER						18. Mother's Name (First, Middle, Maiden Surname) SABINA (UNOBTAINABLE)																				
19e. Informant's Name/Relationship (Type, Print) DR. HERBERT PLUZNICK/SON						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8004 INSPECTION HOUSE RD. POTOMAC, MD 20854																				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):				20b. Place of Disposition (Name of cemetery, crematory or other place) KIRYAT SHAUL CEMETERY		Date 10-2-00		20c. Location - City or Town, State TEL-AVIV, ISRAEL																		
21. Signature of Funeral Service Licensee						22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPEL, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852																				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																										
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>GANGRENE</td> <td>Due to (or as a consequence of):</td> <td>1 month</td> </tr> <tr> <td>b.</td> <td>Peripheral Vascular Disease</td> <td>Due to (or as a consequence of):</td> <td>1 year</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	GANGRENE	Due to (or as a consequence of):	1 month	b.	Peripheral Vascular Disease	Due to (or as a consequence of):	1 year	c.		Due to (or as a consequence of):		d.		Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	GANGRENE	Due to (or as a consequence of):	1 month																						
	b.	Peripheral Vascular Disease	Due to (or as a consequence of):	1 year																						
	c.		Due to (or as a consequence of):																							
	d.		Due to (or as a consequence of):																							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerotic Heart Disease Anemia																										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																										
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)																				
29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																										
29b. Signature and title of certifier Peter B. Sherer MD						29c. License number D 21910		29d. Date signed (Month, Day, Year) October 2, 2000																		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter B. Sherer MD 3921 Ferrara Dr. Wheaton, MD 20906																										
State Registrar		31. Date filed (Month, Day, Year) OCT 06 2000		32. Registrar's Signature B. Sparks																						

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32818

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Amelia Theresa Keller				2. Date of Death Month: October Day: 3, Year: 2000		3. Time of Death 8:30 AM		
	4a. Facility Name (If not institution, give street and number) 1110 Grandin Avenue				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 175-20-6170		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 29, 1926		
	9. Birthplace (State or Foreign Country) Pennsylvania		10a. State Md.		10b. County Montgomery		10c. City, Town or Location Rockville		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1110 Grandin Avenue		10f. Zip Code 20851		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hostess		16b. Kind of Business/Industry Marriott Corp.		17. Father's Name (First, Middle, Last) Peter Winovich		18. Mother's Name (First, Middle, Maiden Surname) Josephine Stringer	
19a. Informant's Name/Relationship (Type, Print) Michael J. Keller (Husband)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1110 Grandin Ave. Rockville, Md. 20851		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Silver Spring, Md.	
21. Signature of Funeral Service Licensee Curtis E. Day		22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ventricular Fibrillation Due to (or as a consequence of): b. Congestive Heart Failure Due to (or as a consequence of): c. Dilated Cardiomyopathy Due to (or as a consequence of): d. Atrial Fibrillation Approximate Interval Between Onset and Death 5 minutes 3 years 3 years 3 years		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Hypertension		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier		29c. License number D41520		29d. Date signed (Month, Day, Year) October 3, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark Milner, M.D., 6410 Rockledge Drive, Bethesda, MD 20817	
31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature B. Sparks		33. State Registrar		34. State Registrar		35. State Registrar	

ORIGINAL



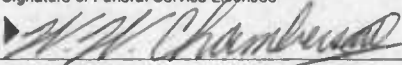
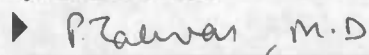
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32819

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAN ROBERT KAUTSKY</b>						2. Date of Death Month <b>SEPT.</b> Day <b>30,</b> Year <b>2000</b>		3. Time of Death <b>10:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SUBURBAN HOSPITAL</b>						4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>213-56-9052</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>51</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 15, 1949</b>		9. Birthplace (State or Foreign Country) <b>HAWAII</b>	
	Usual Residence of Decedent									
10a. State <b>MD.</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>SILVER SPRING</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>3823 GREENLY ST.</b>						10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+) <b>1</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CLERK</b>				16b. Kind of Business/Industry <b>LINENS AND THINGS</b>		
17. Father's Name (First, Middle, Last) <b>ROBERT KARL KAUTSKY</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>MARJORIE STOLTZ</b>				
19a. Informant's Name/Relationship (Type, Print) <b>KAREN KAUTSKY/SISTER</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ITEM #10</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHAMBERS CREMATORY</b>		Date <b>10/2/00</b>		20c. Location - City or Town, State <b>RIVERDALE, MD.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20906</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Immediate Cause (Final disease or condition resulting in death)			a. <b>SEPSIS</b> Due to (or as a consequence of):				Approximate Interval Between Onset and Death <b>WEEKS</b>			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			b. <b>ISCHEMIA OF BOWEL</b> Due to (or as a consequence of):							
			c. Due to (or as a consequence of):							
			d. Due to (or as a consequence of):							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)								28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier  M.D.						29c. License number <b>D 36552</b>		29d. Date signed (Month, Day, Year) <b>OCTOBER 2, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>P. ZARWAR, 50 W. Edmonston Dr. #401 Rockville MD, 20852</b>										
31. Date filed (Month, Day, Year) <b>OCT 03 2000</b>			32. Registrar's Signature 							

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32820

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DAVID KATZ

2. Date of Death

Month Day Year  
OCTOBER 3, 2000

3. Time of Death

3:00 AM

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

079-12-3436

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MARCH 3, 1918

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10e. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6121 MONTROSE ROAD

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOME BUILDER

16b. Kind of Business/Industry

BUILDING

17. Father's Name (First, Middle, Last)

LOUIS KATZ

18. Mother's Name (First, Middle, Maiden Surname)

SADIE KANTOR

19a. Informant's Name/Relationship (Type, Print)

MIMI KATZ/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8101 CONNECTICUT AVE SOUTH 506, CHEVY CHASE, MD 20815

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

JUDEAN MEMORIAL GARDENS

Date

OCT 4,  
2000

20c. Location - City or Town, State

OLNEY, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Encephalopathy, herpes zoster

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gregory A. Compton MD

29c. License number

D24942

29d. Date signed (Month, Day, Year)

OCT 03 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORY A. COMPTON 6121 Montrose Rd Rockville MD

31. Date filed (Month, Day, Year)

OCT 04 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first of these is the fact that the

the second is the fact that the

the third is the fact that the

the fourth is the fact that the

the fifth is the fact that the

the sixth is the fact that the

the seventh is the fact that the

the eighth is the fact that the

the ninth is the fact that the

the tenth is the fact that the

the eleventh is the fact that the

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the thirteenth is the fact that the

the fourteenth is the fact that the

the fifteenth is the fact that the

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the seventeenth is the fact that the

the eighteenth is the fact that the

the nineteenth is the fact that the

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the twenty-first is the fact that the

the twenty-second is the fact that the

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the twenty-fifth is the fact that the

the twenty-sixth is the fact that the

the twenty-seventh is the fact that the

the twenty-eighth is the fact that the

the twenty-ninth is the fact that the

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the thirty-fifth is the fact that the

the thirty-sixth is the fact that the

the thirty-seventh is the fact that the

the thirty-eighth is the fact that the

the thirty-ninth is the fact that the

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the forty-second is the fact that the

the forty-third is the fact that the

the forty-fourth is the fact that the

the forty-fifth is the fact that the

the forty-sixth is the fact that the

the forty-seventh is the fact that the

the forty-eighth is the fact that the

the forty-ninth is the fact that the

the fiftieth is the fact that the

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State of Maryland / Department of Health and Mental Hygiene

00 32821

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>DAVID W. LAUR</b>		2. Date of Death Month <b>7</b> Day <b>29</b> Year <b>00</b>		3. Time of Death <b>0048</b>
4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
5. Social Security Number <b>219-26-3515</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>62</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>3-15-38</b>	9. Birthplace (State or Foreign Country) <b>MD.</b>
Usual Residence of Decedent				
10a. State <b>MD.</b>	10b. County <b>WORCESTER</b>	10c. City, Town or Location <b>OCEAN PINES</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>15 HERON ISLE CT.</b>		10f. Zip Code <b>21811</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MERCHANT</b>		16b. Kind of Business/Industry <b>RETAIL</b>		
17. Father's Name (First, Middle, Last) <b>LOUIS LAUR</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>GLENDORA STEINBERG</b>		
19a. Informant's Name/Relationship (Type, Print) <b>JOANNE LAUR</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15 HERON CT. OCEAN PINES, MD. 21811</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SALISBURY CREMATORY</b>		20c. Location - City or Town, State <b>9-30 SALISBURY, MD.</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>ULLRICH FUNERAL HOME BERLIN, MD. 21811</b>		

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>2000</b>	
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
29b. Signature and title of certifier <b>Nicholas L. Ogden MD.</b>		29c. License number <b>34593</b>	
29d. Date signed (Month, Day, Year) <b>9/29/00</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>NICHOLAS L. OGDEN MD 201 PINE BLUFF RD FORT ST SALISBURY, MD 21811</b>	
31. Date filed (Month, Day, Year) <b>OCT 02 2000</b>		32. Registrar's Signature 	

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32822

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VICKI B. LIVELY

2. Date of Death  
Month Day Year  
October 1 20003. Time of Death  
0930

4a. Facility Name (If not institution, give street and number)

19012 HIGHPOINT DRIVE

4b. City, Town, or Location of Death

GAITHERSBURG

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

225-70-3352

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

July 30, 1948

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19012 High Point Drive

10f. Zip Code

20879

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Virgil Garland Beavers

18. Mother's Name (First, Middle, Maiden Surname)

Theada Stewart

19a. Informant's Name/Relationship (Type, Print)

Mark B. Lively/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19012 High Point Drive, Gaithersburg, Maryland

20879

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery Crematorium, Inc.

Date

October

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00335

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.

300 West Montgomery Avenue, Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. AORTOSCOTIC CAROTIDOCULAL DISSECT

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALCOHOLISM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D5236

29d. Date signed (Month, Day, Year)

October 1, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. I. MARGOLIS, M.D. (OMB) 1115 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 03 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00-32823

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nunzio Charles Lipuma

2. Date of Death

September 28, 2000

3. Time of Death

10:20 A.M.

4a. Facility Name (If not institution, give street and number)

Heartland Healthcare Center

4b. City, Town, or Location of Death

Adelphi

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

133-09-3537

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 20, 1923

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1204 Schindler Drive

10f. Zip Code

20903

10g. Citizen of What Country?

United States of America

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1942-1944

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Computer Systems Analyst

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Antonio Lipuma

18. Mother's Name (First, Middle, Maiden Surname)

Leonardo Messina

19a. Informant's Name/Relationship (Type, Print)

Susan Lipuma/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1204 Schindler Drive, Silver Spring, Maryland 20903

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Crematory

Date

9-30-2000 Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hines-Rinaldi Funeral Home, Inc.

11800 New Hampshire Avenue, Silver Spring, Maryland 20904-2891

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Multiple Injuries with Long Term Complications

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

Inquiry

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

02-17-1972

28b. Time of Injury

unknown M

28c. Injury at Work?

1 ☒ Yes 2 ☐ No

28d. Describe how injury occurred

Subject struck by automobile.

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Sidewalk

28f. Location (Street and Number or Rural Route Number, City or Town, State) 7th and D Streets Washington, D.C.

29e. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

October 13, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Radentz, M.D.

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 20 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 444-6666.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

208-108



100-100-100

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32824

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elaine M. Lidji</b>						2. Date of Death Month Day Year <b>October 3, 2000</b>			3. Time of Death <b>9:00 pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>4215 Isbell Street</b>						4b. City, Town, or Location of Death <b>Wheaton</b>			4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>248-54-3335</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>64</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>Apr 6, 1936</b>	9. Birthplace (State or Foreign Country) <b>South Carolina</b>
	Usual Residence of Decedent											
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Wheaton</b>						10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>4215 Isbell Street</b>				10f. Zip Code <b>20906</b>				10g. Citizen of What Country? <b>USA</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>						16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>			
17. Father's Name (First, Middle, Last) <b>Isaac Marlowe</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Cora Thomas</b>						
19a. Informant's Name/Relationship (Type, Print) <b>John Lidji / Husband</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4215 Isbell Street, Wheaton, MD 20906</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>George Washington Cemetery 2000</b>				Date <b>10/5</b>		20c. Location - City or Town, State <b>Adelphi, MD</b>		
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
Immediate Cause (Final disease or condition resulting in death)												
a. <b>Cardiopulmonary Failure</b> Acute												
Due to (or as a consequence of):												
b. <b>Lung Cancer</b> Chronic												
Due to (or as a consequence of):												
c. Due to (or as a consequence of):												
d. Due to (or as a consequence of):												
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown												
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
25. Was case referred to medicat examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. Signature and title of certifier 						29c. License number <b>D 53177</b>			29d. Date signed (Month, Day, Year) <b>October 4, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John Walmark, MD 9707 Medical Center Drive #300, Rockville, MD</b>												
31. Date filed (Month, Day, Year) <b>OCT 05 2000</b>						32. Registrar's Signature 						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32825

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Barbara Ann Leonard				2. Date of Death Month Day Year September 26, 2000				3. Time of Death 5:00 AM		
	4a. Facility Name (If not Institution, give street and number) 4717 Flower Valley Drive				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 270-26-8087		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 9, 1930		9. Birthplace (State or Foreign Country) Ohio		
	Usual Residence of Decedent				10c. City, Town or Location Rockville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
10e. State Maryland		10b. County Montgomery		10f. Zip Code 20853				10g. Citizen of What Country? United States			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary				16b. Kind of Business/Industry High School			
17. Father's Name (First, Middle, Last) Adam Wecht				18. Mother's Name (First, Middle, Maiden Surname) Gladys Kindler							
19a. Informant's Name/Relationship (Type, Print) Leonard R. Leonard, Jr./Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4717 Flower Valley Drive, Rockville, Maryland 20853							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		Date September 28, 2000		20c. Location - City or Town, State Bethesda, Maryland			
21. Signature of Funeral Service Licensee MO1126				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				a. Stage IV Endometrial Cancer Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.				Approximate Interval Between Onset and Death 1 Year, 11 Months			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Carolyn B. Hendricks MD				29c. License number D37236		29d. Date signed (Month, Day, Year) September 26, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carolyn B. Hendricks, M.D. 6410 Rockledge Drive, Bethesda, Maryland 20817											
31. Date filed (Month, Day, Year) OCT 02 2000				32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32826

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward Benedict Landry		2. Date of Death Month Day Year October 2, 2000		3. Time of Death 8:15 AM	
	4a. Facility Name (If not institution, give street and number) Maplewood Park Place		4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 365-01-4403	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 12, 1906
	9. Birthplace (State or Foreign Country) Massachusetts					
To Be Completed by Funeral Director	Usual Residence of Decedent					
	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda	
	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	10e. Street and Number 9707 Old Georgetown Road		10f. Zip Code 20814		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: White					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Safety Engineer		16b. Kind of Business/Industry Safety	
	17. Father's Name (First, Middle, Last) Delphis A. Landry		18. Mother's Name (First, Middle, Maiden Surname) Emily Anna Beaubien			
	19a. Informant's Name/Relationship (Type, Print) Joanne L. Robinson/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8301 River Falls Drive, Potomac, Maryland 20854			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Highland Cemetery		20c. Location - City or Town, State Norwood, Massachusetts	
21. Signature of Funeral Service Licensee  M00198		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Cerebrovascular Arteriosclerosis Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death 20 years
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
	29b. Signature and title of certifier 		29c. License number D42423		29d. Date signed (Month, Day, Year) October 2, 1999	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. Robert Mozayeni, M.D. 5530 Wisconsin Avenue #1208, Chevy Chase, Maryland 20815						
State Registrar	31. Date filed (Month, Day, Year) OCT 03 2000		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32827

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES H. LAKEMAN, JR.</b>				2. Date of Death Month Day Year <b>OCTOBER 4, 2000</b>				3. Time of Death <b>9:52 am</b>		
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>				4c. County of Death <b>MONTGOMERY</b>		
Funeral Director	5. Social Security Number <b>214-48-8817</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>54</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Apr 5, 1946</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Olney</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10e. Street and Number <b>3616 Sundown Farms Way</b>		10f. Zip Code <b>20830</b>		10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b> College (1-4or 5+) <b>1</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Medical Claims Processor</b>		16b. Kind of Business/Industry <b>Teamsters Union</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
17. Father's Name (First, Middle, Last) <b>James H. Lakeman, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Evelyn Stehle</b>				19a. Informant's Name/Relationship (Type, Print) <b>Irene M. Lakeman / Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3616 Sundown Farms Way, Olney, MD 20830</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		20c. Location - City or Town, State <b>10/9/00 Silver Spring, MD</b>		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Myocardial Infarction</b> Due to (or as a consequence of):  b. <b>Coronary Artery Disease</b> Due to (or as a consequence of):  c. <b>Diabetes Mellitus Type I</b> Due to (or as a consequence of):  d.  Approximate Interval Between Onset and Death  minutes  years  years	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier  M.D.				29c. License number <b>037024</b>			
29d. Date signed (Month, Day, Year) <b>October 04, 2000</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David G. Srour, MD Shady Grove Adventist Hospital 9901 Medical Center Dr. Rockville, MD 20850</b>							
31. Date filed (Month, Day, Year) <b>OCT 06 2000</b>				32. Registrar's Signature 							

ORIGINAL



## Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>DANIEL JOSEPH LOVELY</b>		2. Date of Death Month <b>SEPT.</b> Day <b>30</b> , Year <b>2000</b>		3. Time of Death <b>0227 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>605 WEST JOPPA ROAD</b>		4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
5. Social Security Number <b>216-90-0867</b>	6. Sex <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>34</b> Yrs.	If Under 1 Year Months Days	8. Date of Birth (Month, Day, Year) <b>April 4, 1966</b>	9. Birthplace (State or Foreign Country) <b>Florida</b>
Usual Residence of Decedent					
10a. State <b>Maryland</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Towson</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>11 Danforth Court</b>		10f. Zip Code <b>21204</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>1</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Chef</b>		16b. Kind of Business/Industry <b>Culinary</b>			
17. Father's Name (First, Middle, Last) <b>Robert E. Lovely Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Jean F. Donahue</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Amy Jo Lovely/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>202 Eastridge Garth, Timonium, MD 21093</b>			
20a. Method of Disposition <b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		20c. Location - City or Town, State <b>10/2/00 Salisbury, MD</b>	
21. Signature of Funeral Service Licensee <b>Keith R. Downey</b>		22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple injuries</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		23b. Did tobacco use contribute to the cause of death? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No <b>3</b> <input type="checkbox"/> Probably <b>4</b> <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <b>1</b> <input checked="" type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> <input checked="" type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
25. Was case referred to medical examiner? <b>1</b> <input checked="" type="checkbox"/> Yes <b>2</b> <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA Other: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>			
27. Manner of Death <b>1</b> <input type="checkbox"/> Natural <b>2</b> <input checked="" type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>5</b> <input type="checkbox"/> Pending investigation <b>6</b> <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Found 9/30/00 at 3:15 PM</b>		28b. Time of Injury <b>3:15 PM</b>	
28c. Injury at Work? <b>1</b> <input type="checkbox"/> Yes <b>2</b> <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject reduction struck by vehicle</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>605 West Joppa Road Baltimore County Maryland</b>	
29a. Certifier (Check only one) <b>1</b> <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Theodore M. King</b>		29c. License number <b>O.C.M.E</b>	
29d. Date signed (Month, Day, Year) <b>SEPT. 30, 2000</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Theodore M. King 111 Penn Street, Baltimore, Maryland 21201</b>			
31. Date filed (Month, Day, Year) <b>OCT 04 2000</b>		32. Registrar's Signature <b>B. Sparks</b>			

John A. [unclear]



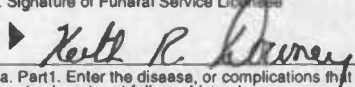
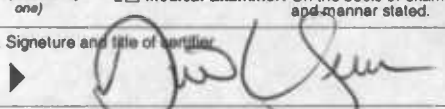
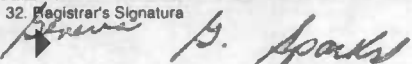
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32829

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HERBERT WHITE LEJEUNE</b>		2. Date of Death Month <b>OCTOBER</b> Day <b>1</b> Year <b>2000</b>		3. Time of Death <b>4:16 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>438-46-8213</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>March 10, 1933</b>		9. Birthplace (State or Foreign Country) <b>Louisiana</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>Maryland</b>	10b. County <b>Wicomico</b>	10c. City, Town or Location <b>Salisbury</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>812 Gettysburg Ave.</b>		10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Army</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Craftsman</b>		16b. Kind of Business/Industry <b>Building</b>
	17. Father's Name (First, Middle, Last) <b>Jesse Lejeune</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Ivaline Baker</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Donison Lejeune/Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>812 Gettysburg Ave., Salisbury, MD 21804</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Springhill Memory Gardens</b>		Date <b>10/5/00</b> 20c. Location - City or Town, State <b>Hebron, MD</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death
	a. <b>Spangrene of GI Tract</b> Due to (or as a consequence of):				<b>5d</b>
	b. <b>Whipple Procedure</b> Due to (or as a consequence of):				<b>1 month</b>
	c. <b>Amputatory Carcinoma</b> Due to (or as a consequence of):				<b>unknown.</b>
Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>
			28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
			28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. Signature and title of certifier 		29c. License number <b>051743</b>		29d. Date signed (Month, Day, Year) <b>10/04/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David L. Sechler MD 145 E. Carroll Street Salisbury MD 21801</b>					
31. Date filed (Month, Day, Year) <b>OCT 04 2000</b>		32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32830

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ballard Milbourne</b>		2. Date of Death Month <b>September</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>0618</b>
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>		4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>
Funeral Director	5. Social Security Number <b>219-01-3277</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>5-9-11</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Somerset</b>	10c. City, Town or Location <b>Westover</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>P.O. Box 161</b>		10f. Zip Code <b>21871</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) <b>6th grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Meat Cutter</b>		16b. Kind of Business/Industry <b>Johnson Meat Co</b>
	17. Father's Name (First, Middle, Last) <b>John Milbourne</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Hester</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Edna Brooke (daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 341 Westover, Md. 21871</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>John Wesley Cemetery</b>		20c. Location - City or Town, State <b>Westover Md</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Bennie Smith Funeral Home P.O. Box 331 Pocomoke City, Md.</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>STATUS EPILEPTICUS</b></p> <p>Due to (or as a consequence of):</p> <p>b. <b>CEREBRAL HEMORRHAGE</b></p> <p>Due to (or as a consequence of):</p> <p>c. <b>MYELOFIBROSIS</b></p> <p>Due to (or as a consequence of):</p> <p>d.</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> </div> </div>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <input checked="" type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D 50753</b>		29d. Date signed (Month, Day, Year) <b>09/30/00</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>CHARLES BOLASADE, MD 108 PINEBLUFF RD SALISBURY MD</b>					
31. Date filed (Month, Day, Year) <b>OCT 06 2000</b>		32. Registrar's Signature 			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32831

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) AGNES THOMAS MORRIS						2. Date of Death Month Day Year Sept 28 2000		3. Time of Death 2045		
	4a. Facility Name (If not institution, give street and number) The Memorial Hospital						4b. City, Town, or Location of Death Easton		4c. County of Death Talbot		
Funeral Director	5. Social Security Number 220-12-0541		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 92 Yrs.		8. Date of Birth (Month, Day, Year) MAY 23, 1908		9. Birthplace (State or Foreign Country) MARYLAND		
	Usual Residence of Decedent										
10a. State MD		10b. County TALBOT		10c. City, Town or Location EASTON				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 201 FEDERAL ST.				10f. Zip Code 21601		10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SALES CLERK			16b. Kind of Business/Industry VARIETY STORE				
17. Father's Name (First, Middle, Last) WILLIAM MARTIN THOMAS						18. Mother's Name (First, Middle, Maiden Surname) JANE L. HARPER					
19a. Informant's Name/Relationship (Type, Print) THELMA M. FLUHARTY/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7901 PEANECK RD, ST. MICHAELS, MD 21663							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) WASHINGTON UNITY CEMETERY		Date 10-2-2000		20c. Location - City or Town, State HURLOCK, MD			
21. Signature of Funeral Service Licensee <i>Murice E. Newnam</i>				22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Necrosis of Bowel</i> Due to (or as a consequence of): b. <i>Mesenteric Vascular occlusion</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 3 days 2 weeks	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ASHD with Complete Heart Block</i>								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>Wm H Wood Jr MD</i>				29c. License number 1208715		29d. Date signed (Month, Day, Year) 9/29/00					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM H. WOOD, JR M.D. 505 IDLEWILD AVE., EASTON, MD 21601											
31. Date filed (Month, Day, Year) OCT 02 2000		32. Registrar's Signature <i>Sparks</i>									

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Agnes Thomas Morris

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32832

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ira B. Mullis Jr.

2. Date of Death

Month Day Year  
October 1, 2000

3. Time of Death

535pm

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

505-12-8544

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug 29, 1921

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

14700 Claude La

10f. Zip Code

20905

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates: 43-44

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrical Engineer

16b. Kind of Business/Industry

Johns Hopkins Univ.

APL

17. Father's Name (First, Middle, Last)

Ira B. Mullis

18. Mother's Name (First, Middle, Maiden Surname)

Annie Duckett

19a. Informant's Name/Relationship (Type, Print)

Janet Mullis /Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14700 Claude La, Silver Spring, MD 20905

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Data

Oct 3

2000

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Beverly L. Hellett

22. Name and Address of Facility

Rapp Funeral &amp; Cremation Services

933 Gist Avenue Silver Spring, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Respiratory arrest

a. Due to (or as a consequence of):

Congestive heart failure, refractory

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus, end stage renal disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Alan R Segal M.D.

29c. License number

D52261

29d. Date signed (Month, Day, Year)

October 02, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan R Segal M.D. 1299 Lambertson Driver, Silver Spring, MD 20902

31. Date filed (Month, Day, Year)

OCT 04 2000

32. Registrar's Signature

Jennifer B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32833

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lawrence Payne Monnier				2. Date of Death Month Day Year October 1, 2000				3. Time of Death 1220pm	
	4a. Facility Name (If not institution, give street and number) 15005 Good Meadow Ct.				4b. City, Town, or Location of Death Gaithersburg				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 379-42-0575		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) Sep 6, 1942		9. Birthplace (State or Foreign Country) MI	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Montgomery		10c. City, Town or Location Gaithersburg				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number 15005 Good Meadow Ct.				10f. Zip Code 20878		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 66-88		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College 3+ (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Systems Engineer				16b. Kind of Business/Industry Defense Travel	
	17. Father's Name (First, Middle, Last) Lawrence Edward Monnier				18. Mother's Name (First, Middle, Maiden Surname) Thelma Pearl Payne					
	19a. Informant's Name/Relationship (Type, Print) Diane Monnier /Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15005 Good Meadow Ct., Gaithersburg, MD 20878					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date Oct 5 2000		20c. Location - City or Town, State Beltsville, MD			
	21. Signature of Funeral Service Licensee Beverly L. Hall				22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Avenue Silver Spring, MD					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Metastatic Lung Cancer				Due to (or as a consequence of):				Approximate Interval Between Onset and Death 7 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Due to (or as a consequence of):						
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pleural Effusion								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier T. Fogarty				29c. License number VA 0101-057098				29d. Date signed (Month, Day, Year) 10/02/00	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patrick F. Fogarty M.D. Bldg. 10 Rm 7C103 9000 Rockville Pk, Bethesda, MD 20892									
	State Registrar	31. Date filed (Month, Day, Year) OCT 04 2000				32. Registrar's Signature B. Sparks				

100-100000

100-100000

100-100000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32834

Amend #6, 10/2/2000, BMW, Montg. Co.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ABDEL GAFOR, MOHAMED NOR.</b>		2. Date of Death Month: <b>Sept</b> Day: <b>28</b> Year: <b>2000</b>		3. Time of Death <b>1705</b>
	4a. Facility Name (If not institution, give street and number) <b>HOWARD COUNTY GENERAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>COLUMBIA</b>		4c. County of Death <b>HOWARD</b>
Funeral Director	5. Social Security Number <b>Unknown</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>MAR. 2. 1929</b>	9. Birthplace (State or Foreign Country) <b>Sudan</b>
	Usual Residence of Decedent				
10a. State <b>Maryland</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Columbia</b>	
10e. Street and Number <b>5208 Cedar La.</b>		10f. Zip Code <b>21044</b>		10g. Citizen of What Country? <b>Sudan</b>	
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Merchant</b>		16b. Kind of Business/Industry <b>Trader</b>	
17. Father's Name (First, Middle, Last) <b>Mohamednor Awad</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Zeinab M. Ayob</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Mohamed A. Mohamed-Son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5208 Cedar La., Columbia, Md. 21044</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Geo. Wash. Cemeter.</b>		20c. Location - City or Town, State <b>9-30-2000 Adelphi, Md.</b>	
21. Signature of Funeral Service Licensee <b>Pamela M. Matar</b>		22. Name and Address of Facility <b>Universal II Mortuary Inc. 411 Kennedy St., N.W., Wash, D.C.</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Pneumonia with Pleural Effusion</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Severe Cardiomyopathy</b> <b>Congestive Heart Failure</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):					Approximate Interval Between Onset and Death <b>3 days</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Severe Cardiomyopathy</b> <b>Congestive Heart Failure</b>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b></b>		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b></b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b></b>	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Pamela M. Matar M.D.</b>		29c. License number <b>D 24721</b>		29d. Date signed (Month, Day, Year) <b>9/29/2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Syed Sabir, 14333 Laurel Bowie Rd. LAUREL, MD 20708</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>OCT 02 2000</b>		32. Registrar's Signature <b>B. Sparks</b>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32835

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Eustaquio Mejia				2. Date of Death Month Day Year October 4, 2000				3. Time of Death 1042am		
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 219-90-2566		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) Nov 1, 1919		9. Birthplace (State or Foreign Country) Cuzco, Peru		10a. State MD		10b. County Montgomery		10c. City, Town or Location Wheaton		
Usual Residence of Decedent											
10a. State MD				10b. County Montgomery				10c. City, Town or Location Wheaton			
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 11817 Idlewood Rd				10f. Zip Code 20906		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: South American			14. Race - American Indian, Black, White, etc. Specify: Hispanic		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Military Police				16b. Kind of Business/Industry Peru Government			
17. Father's Name (First, Middle, Last) Demetrio Mejia						18. Mother's Name (First, Middle, Maiden Surname) Isabel Quispe					
19a. Informant's Name/Relationship (Type, Print) Jesus Mejia / Son						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4318 Aspen Hill Rd., Rockville, MD 20853					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Puerto Maldonado		Data Oct 14 2000		20c. Location - City or Town, State Madre De Dios, Peru,			
21. Signature of Funeral Service Licensee Beverly L. Hallock				22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Avenue Silver Spring, MD							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspiration pneumonia Dysphagia Stroke Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
Approximate Interval Between Onset and Death Minutes											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28a. Place of Injury - At home, term, street, factory, office building, etc. (Specify)				28e. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier B. Sparks				29c. License number D42518				29d. Date signed (Month, Day, Year) October 4, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gul Chablani M.D. 11119 Rockville Pk. # 401, Rockville, MD 20852											
31. Date filed (Month, Day, Year) OCT 06 2000				32. Registrar's Signature B. Sparks							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32836

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NASSER

MEHDIKHANI

2. Date of Death

Month

Day

Year

Sept.

26

2000

3. Time of Death

1644

4a. Facility Name (If not institution, give street and number)

CARROLL COUNTY HOSPITAL

4b. City, Town, or Location of Death

Westminister

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

215-76-6698

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

2-23-43

9. Birthplace (State or Foreign Country)

Iran

Usual Residence of Decedent

10e. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

354 Chiseled Stone Rd.

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Professor of Education

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Ismail Mehikhani

18. Mother's Name (First, Middle, Maiden Surname)

Kahdijeh Sadat

19a. Informant's Name/Relationship (Type, Print)

Kobra Homayoun - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

354 Chiseled Stone Rd, Sykesville, Md. 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Geo. Washington Cemet. 9-28-2000 Adelphi, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Universal II Mortuary Inc.  
411 Kennedy St, N.W., Wash, D.C.

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

acute myocardial infarction terminal

Due to (or as a consequence of):

arteriosclerotic heart disease 22 yrs

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D12121

29d. Date signed (Month, Day, Year)

9-28-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George F. Sengstack, M.D. 3929 Ferrara Dr., Wheaton, Maryland 20906

31. Date filed (Month, Day, Year)

OCT 02 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32837

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Corinne Colton McKenna

2. Date of Death

Month Day Year  
Sept. 26, 2000

3. Time of Death

7:55 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

9307 Kendale Rd.

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

5. Social Security Number

216-44-9759

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 22, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9307 Kendale Road

10f. Zip Code

20854

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Richard Colton

18. Mother's Name (First, Middle, Maiden Surname)

Emily Hodges

19a. Informant's Name/Relationship (Type, Print)

Richard Colton/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13616 Old Chapel Rd. Bowie, Maryland 20720

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Gate of Heaven

Date

Sept. 30,

2000

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

2222 Wisconsin Ave., N.W.

Washington, D.C. 20007

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

Cerebral Vascular Disease

6 months

Due to (or as a consequence of):

Cerebral Thrombosis

Due to (or as a consequence of):

Right Hemiplegia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DO-1948

29d. Date signed (Month, Day, Year)

9/28/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Blaine Fitzgerald, M.D. 8218 Wisconsin Ave., Bethesda, MD 20814

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 02 2000

32. Registrar's Signature

Geneva B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

10

*Handwritten signature or mark*



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32838

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Paul Marks				2. Date of Death Month Day Year September 30, 2000				3. Time of Death 1:20am	
	4a. Facility Name (If not institution, give street and number) Hebrew Home of Greater Washington				4b. City, Town, or Location of Death Rockville				4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 085-14-2082		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 87 Yrs.		8. Date of Birth (Month, Day, Year) March 7, 1913		9. Birthplace (State or Foreign Country) New York	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 6121 Montrose Road				10f. Zip Code 20852		10g. Citizen of What Country? United States			
	11. Marital Status 1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Civil Service				16b. Kind of Business/Industry United States Government	
	17. Father's Name (First, Middle, Last) Ellis Marks				18. Mother's Name (First, Middle, Maiden Surname) Lena Cohen					
	19a. Informant's Name/Relationship (Type, Print) Mike T. Reinhardt / Law Brother-in-				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5805 Dewey Street, Cheverly, MD 20785					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Data 10/03/00		20c. Location - City or Town, State Brentwood, MD			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Danzansky Goldberg Memorial Chapel, Inc. 1170 Rockville Pike, Rockville, MD 20852					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE RENAL FAILURE Due to (or as a consequence of): b. CARCINOMA OF PROSTATE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown									
23c. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
23d. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 12				29c. License number D05885				29d. Date signed (Month, Day, Year) 09/30/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEVEN LIPSON 6121 MONTROSE ROAD ROCKVILLE, MD										
31. Date filed (Month, Day, Year) OCT 04 2000				32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23c show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

*[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32839

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ayelech Mamo				2. Date of Death Month Day Year SEPT. 28, 2000				3. Time of Death 0559 AM		
	4a. Facility Name (If not institution, give street and number) HOLY CROSS HOSPITAL				4b. City, Town, or Location of Death SILVER SPRING				4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number None		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 45 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) April 10, 1955		9. Birthplace (State or Foreign Country) Ethiopia		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Damascus		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 26902 Howard Chapel Drive		10f. Zip Code 20872		10g. Citizen of What Country? Ethiopia			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Babysitter	
16b. Kind of Business/Industry Private		17. Father's Name (First, Middle, Last) Mamo G/Michael		18. Mother's Name (First, Middle, Maiden Surname) Desta Legesse		19a. Informant's Name/Relationship (Type, Print) Tadele Gebrewold Friend		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 East Wayne Ave., Silver Spring, MD 20901			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Silver Spring, MD		20d. Date 10-31-00		21. Signature of Funeral Service Licensee Anchei Thompson		22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Washington, D.C. 20012	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <u>Multiple Injuries</u> Due to (or as a consequence of):		b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):		Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 9/28/00		28b. Time of Injury 0527 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Pedestrian struck by vehicle		28e. Location (Street and Number or Rural Route Number, City or Town, State) Silver Spring, Maryland	
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Joseph Pestaner, M.D.		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) SEPT. 29, 2000		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) OCT 06 2000	
32. Registrar's Signature B. Sparks		33. Date filed (Month, Day, Year) OCT 06 2000		34. Registrar's Signature B. Sparks		35. Date filed (Month, Day, Year) OCT 06 2000		36. Registrar's Signature B. Sparks		37. Date filed (Month, Day, Year) OCT 06 2000	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32840

Certificate of Death

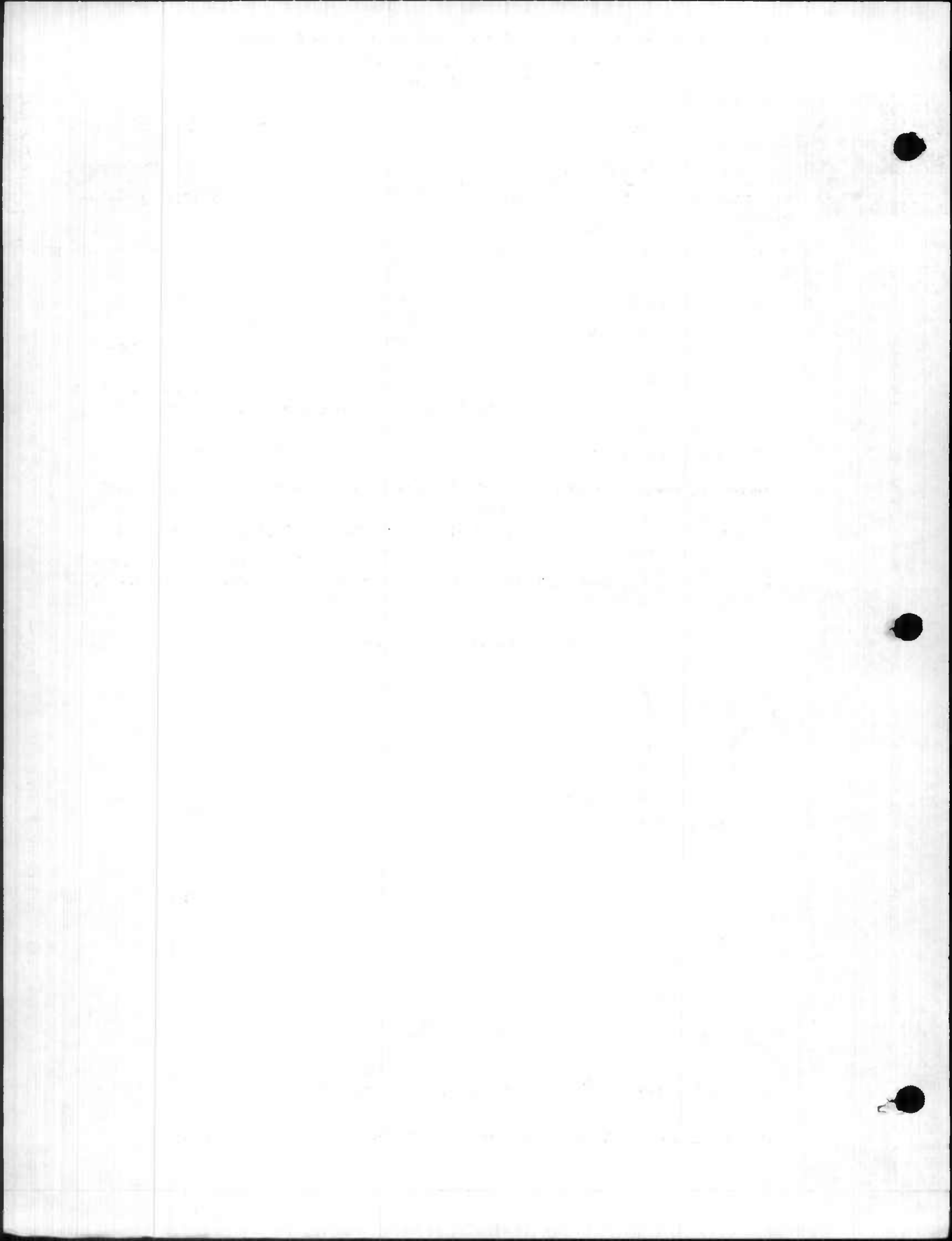
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Raymond N. Moore</b>				2. Date of Death Month <b>October</b> Day <b>10</b> Year <b>2000</b>		3. Time of Death <b>12:20 PM</b>									
	4a. Facility Name (If not institution, give street and number) <b>Cherry Lane Nursing Home</b>				4b. City, Town, or Location of Death <b>Laurel</b>		4c. County of Death <b>Prince George's</b>									
Funeral Director	5. Social Security Number <b>212-20-1558</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 16 1924</b>									
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Laurel</b>									
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>9229 Grant Avenue</b>		10f. Zip Code <b>20723</b>		10g. Citizen of What Country? <b>USA</b>										
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Senior Service Representative</b>		16b. Kind of Business/Industry <b>Baltimore Gas &amp; Electric Co.</b>												
17. Father's Name (First, Middle, Last) <b>Raymond Dewey Moore</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Dasher</b>												
19a. Informant's Name/Relationship (Type, Print) <b>Raymond N. Moore, Jr./Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8903 Spring Avenue, Lanham, Maryland 20706</b>												
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Pauls Church Cem.</b>		Date <b>10/15/00</b>		20c. Location - City or Town, State <b>Fulton, MD</b>										
21. Signature of Funeral Service Licensee  <b>MOOL60</b>				22. Name and Address of Facility <b>Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, Maryland, 20707</b>												
23a. Path - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
<table border="1"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last             </td> <td>a. <b>Chronic Lymphocytic Leukemia</b> Due to (or as a consequence of):</td> <td>Years</td> </tr> <tr> <td>b.  Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.  Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.  Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Chronic Lymphocytic Leukemia</b> Due to (or as a consequence of):	Years	b. Due to (or as a consequence of):		c. Due to (or as a consequence of):		d. Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Chronic Lymphocytic Leukemia</b> Due to (or as a consequence of):	Years														
	b. Due to (or as a consequence of):															
	c. Due to (or as a consequence of):															
	d. Due to (or as a consequence of):															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DM II</b> <b>HTN</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No										
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																
29b. Signature and title of certifier  <b>Pritam S. Saini</b>				29c. License number <b>D28998</b>		29d. Date signed (Month, Day, Year) <b>10-15-2000</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Pritam S. Saini, M.D. 9101 Cherry Lane, Suite 211 Laurel, MD 20708</b>																
31. Date filed (Month, Day, Year) <b>OCT 13 2000</b>				32. Registrar's Signature 												

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32841

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jerome A. Mullett

2. Date of Death

October 6, 2000

3. Time of Death

3:45 pm

4a. Facility Name (If not institution, give street and number)

8118 Forest Hill Drive

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

5. Social Security Number

370-28-8115

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 5, 1930

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8118 Forest Hill Drive

10f. Zip Code

21043

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Asst. General President

16b. Kind of Business/Industry

I.U.E.C.

17. Father's Name (First, Middle, Last)

Michael E. Mullett

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Foltz

19a. Informant's Name/Relationship (Type, Print)

Dan Mullett / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

826 Fairfield Ave. Westminster, MD. 21157

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Data

Oct. 10 2000

20c. Location - City or Town, State

Catonsville, Maryland

21. Signature of Funeral Service Licensee

notogic

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.  
4112 Old Columbia Pike Ellicott City, MD. 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Adenocarcinoma of Unknown Origin metastatic 16 months

Due to (or as a consequence of):

b. To bone, prostate.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic anemia, S/P Radiation to prostate

COPD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Other (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D30573

29d. Date signed (Month, Day, Year)

October 7, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jon K. M. F. MD 11065 Ashle Patuxent Parkway, Columbia

31. Date filed (Month, Day, Year)

OCT 10 2000

32. Registrar's Signature

MD 21044

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

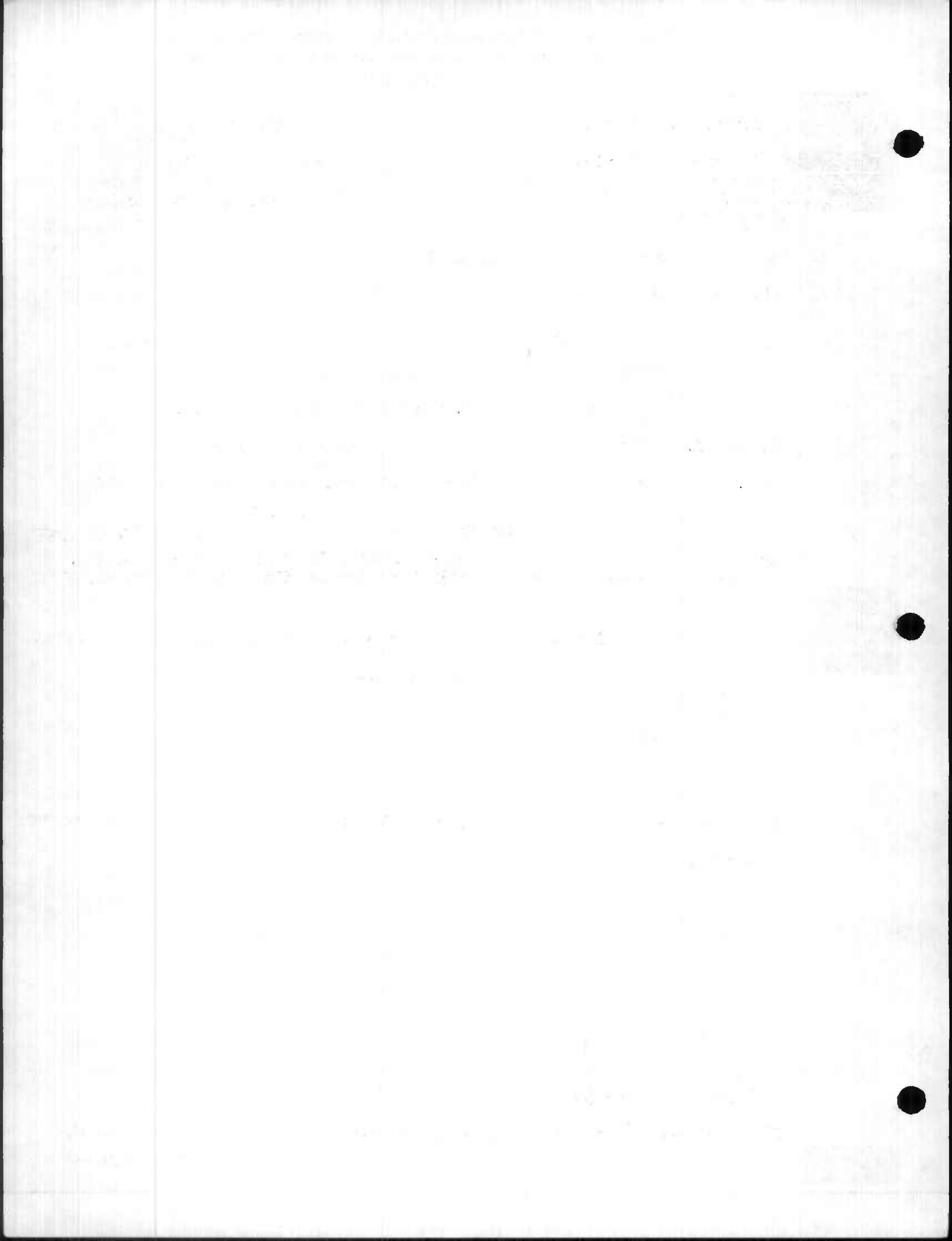
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32842

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

FREDERICK

NAMAN

2. Date of Death

Month

Day

Year

Oct 5 2000

3. Time of Death

0037

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

062-09-6002

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

January 27, 1913

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10308 Nolcrest Drive

10f. Zip Code

20903

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 Years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Accountant, CPA

16b. Kind of Business/Industry

U. S. Government

17. Father's Name (First, Middle, Last)

Abraham Jacob Neuman

18. Mother's Name (First, Middle, Maiden Surname)

Elfreda Linker

19a. Informant's Name/Relationship (Type, Print)

Judith L. Neuman - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12409 New Hampshire Avenue, Silver Spring, Md. 20904

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mount Lebanon Cemetery 10/6/2000 Adelphi, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Donald C. Stottmeyer

22. Name and Address of Facility

Danzansky-Goldberg Memorial Chapels, Inc.

1170 Rockville Pike, Rockville, Maryland 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE MYELOBLASTIC LEUKEMIA

6 mo.

Due to (or as a consequence of):

b. MYELODYSPLASTIC SYNDROME

13 mo.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pancytopenia

Urinary Tract infection

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

2 ☒ Inpatient3 ☐ ER/Outpatient4 ☐ DOA

Other:

5 ☐ Nursing Home6 ☐ Residence7 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
investigation6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

D. J. Adams

29c. License number

D 29675

29d. Date signed (Month, Day, Year)

Oct 5 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ruth V. Bocca, MD 9707 Medical Center Dr Rockville

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 06 2000

32. Registrar's Signature

D. J. Adams

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Page 2 of 2

Page 2 of 2

Page 2 of 2

Page 2 of 2

Page 2 of 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32843

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>TINGSUAN NI</b>		2. Date of Death Month <b>September</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>8:05 P.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>		4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>
Funeral Director	5. Social Security Number <b>212-21-6881</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>July 16, 1921</b>		9. Birthplace (State or Foreign Country) <b>China</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>MD</b>		10b. County <b>Montgomery</b>
	10c. City, Town or Location <b>Kensington</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>10231 Carroll Place</b>		10f. Zip Code <b>20895</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Asian</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Accountant</b>
	16b. Kind of Business/Industry <b>Business</b>		17. Father's Name (First, Middle, Last) <b>Yu Choung Ni</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lan-Yin Chou</b>
	19a. Informant's Name/Relationship (Type, Print) <b>Huey-Chiou Ni, Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10231 Carroll Place, Kensington, MD 20895</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		Date <b>Oct. 6 2000</b>
	20c. Location - City or Town, State <b>Silver Spring, Maryland</b>		21. Signature of Funeral Service Licensee <b>Tracy A. Spivey</b>		22. Name and Address of Facility <b>Devol Funeral Home, 10 East Deer Park Gaithersburg, MD 20877</b>
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>SEPTIC SHOCK</b> Due to (or as a consequence of): a. b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					
28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b> 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Tracy A. Spivey</b>					
29c. License number <b>D 28656</b>					
29d. Date signed (Month, Day, Year) <b>OCTOBER 1, 2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAVI VASSI MD, 8609 SECOND AVENUE, #404B, SILVER SPRING, MD 20910</b>					
31. Date filed (Month, Day, Year) <b>OCT 06 2000</b>					
32. Registrar's Signature <b>B. Spivey</b>					

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32844

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN ANTHONY NUGENT		2. Date of Death Month Day Year September 30, 2000		3. Time of Death 1623
	4a. Facility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		4b. City, Town, or Location of Death SALISBURY		4c. County of Death WICOMICO
Funeral Director	5. Social Security Number 128-22-7838	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 74 Yrs.	8. Date of Birth (Month, Day, Year) April 30, 1926	9. Birthplace (State or Foreign Country) New York
	Usual Residence of Decedent				
10a. State Florida		10b. County Broward	10c. City, Town or Location Deerfield Beach		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number 2059 Southwest 15th St., #225			10f. Zip Code 33442	10g. Citizen of What Country? USA	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Navy If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Attorney	
16b. Kind of Business/Industry Law		17. Father's Name (First, Middle, Last) Daniel Francis Nugent		18. Mother's Name (First, Middle, Maiden Surname) Anna Mary Huschle	
19a. Informant's Name/Relationship (Type, Print) Teresa E. Nugent/Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2059 Southwest 15th St., #225, Deerfield Beach, FL 33442		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Salisbury Crematory		Date 10/4/00	20c. Location - City or Town, State Salisbury, MD
21. Signature of Funeral Service Licensee <i>David H. Thompson</i>			22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804		
23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
<p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>Cardiac Arrest</i> Due to (or as a consequence of): <i>10</i></p> <p>b. <i>Congestive Heart Failure</i> Due to (or as a consequence of): <i>8 yrs</i></p> <p>c. <i>CAD</i> Due to (or as a consequence of): <i>10 yrs</i></p> <p>d.</p>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Renal Failure</i>					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Mark Treuth</i>		29c. License number D0054879	29d. Date signed (Month, Day, Year) 10/11/00
30. Name and address of person who completed cause of death (from 23a) (Type, Print) <i>106 N. Board St Salisbury MD 21801</i>					
31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature <i>B. Sparks</i>			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32845

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARVIN OVALLE</b>				2. Date of Death Month <b>SEPTEMBER</b> Day <b>24</b> Year <b>2000</b>		3. Time of Death <b>0111</b>	
	4a. Facility Name (If not Institution, give street and number) <b>SUBURBAN HOSPITAL</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>N/A</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>30</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 15, 1970</b>	
	9. Birthplace (State or Foreign Country) <b>Guatemala</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Spring</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10a. Street and Number <b>2422 Ross Road, Apt 102</b>				10f. Zip Code <b>20910</b>		10g. Citizen of What Country? <b>Guatemala</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Guatemalan</b>		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Janitor</b>		16b. Kind of Business/Industry <b>Cleaning</b>			
	17. Father's Name (First, Middle, Last) <b>Amado Saul Ovalle</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Onoria Osorio</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Bayron Ovalle / Brother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2422 Ross Road, Apt 102, Silver Spring, MD 20910</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cementerio General</b>		20c. Location - City or Town, State <b>De La Villa De Salcaja, Guatemala</b>		20d. Date <b>10/1/00</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Hemorrhagic Shock</b> Due to (or as a consequence of): b. <b>Upper Gastrointestinal Hemorrhage</b> Due to (or as a consequence of): c. <b>Chronic Alcoholism</b> Due to (or as a consequence of): d.  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Seizure Disorder</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier (One)		29c. License number <b>065236</b>		29d. Date signed (Month, Day, Year) <b>September 24, 2000</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Carl J. Madoculis, MD (One) 11125 Rockville Pike, Rockville, MD 20852</b>								
31. Date filed (Month, Day, Year) <b>OCT 2 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-328-4500.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

**OVALLE MARVIN 9/29/00 01:11AM**

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32846

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edward J. O'Donnell, Sr.				2. Date of Death Month Day Year Sept. 30, 2000		3. Time of Death 11:40 AM	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda, Md.		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 179-12-9876	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 76	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb 9, 1924		9. Birthplace (State or Foreign Country) Wayne, PA.
	Usual Residence of Decedent							
10e. State Maryland		10b. County Montgomery		10c. City, Town or Location Potomac		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 9210 Kentsdale Drive				10f. Zip Code 20854		10g. Citizen of What Country? U.S.A.		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates 1942-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Branch Chief		16b. Kind of Business/Industry Army Material Command		
17. Father's Name (First, Middle, Last) Manus O'Donnell				18. Mother's Name (First, Middle, Maiden Surname) Mary Boyce				
19a. Informant's Name/Relationship (Type, Print) Rita O'Donnell				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15521 Quince Ridge Lane Gaithersburg, Md. 20878				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Fairfax Memorial Park		Date 10-3-00		20c. Location - City or Town, State Fairfax, Virginia		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Money & King Funeral Home, Inc. 171 W. Maple Avenue-Vienna, Virginia 22180				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)		a. <u>Pneumonia</u> Due to (or as a consequence of):					1 week	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		b. <u>Chronic Obstructive Pulmonary Disease</u> Due to (or as a consequence of):					years	
		c. _____ Due to (or as a consequence of):						
		d. _____ Due to (or as a consequence of):						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number 044157		29d. Date signed (Month, Day, Year) October 1, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IRA BERGER M.D. 808 Veirs Mill Road, Rockville, Maryland 20851								
State Registrar	31. Date filed (Month, Day, Year) OCT 02 2000		32. Registrar's Signature 					

ORIGINAL





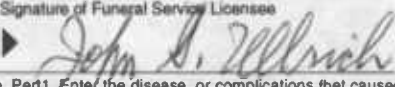
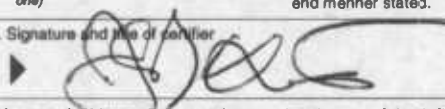
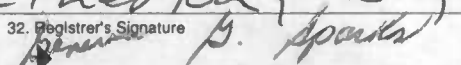
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32847

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM A. PAETOW</b>		2. Date of Death Month <b>10</b> Day <b>3</b> Year <b>2000</b>		3. Time of Death <b>1243</b>
	4e. Facility Name (If not institution, give street and number) <b>ATLANTIC GENERAL HOSPITAL</b>		4b. City, Town, or Location of Death <b>BERLIN</b>		4c. County of Death <b>WORCESTER</b>
Funeral Director	5. Social Security Number <b>094-03-8087</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>8-18-15</b>		9. Birthplace (State or Foreign Country) <b>NY</b>		
Usual Residence of Decedent					
10a. State <b>NY</b>		10b. County <b>ULSTER</b>		10c. City, Town or Location <b>HIGH FALLS</b>	
10e. Street and Number <b>328 MOSSY BROOK RD.</b>		10f. Zip Code <b>12440</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PIANO TUNER</b>		16b. Kind of Business/Industry <b>MUSIC</b>	
17. Father's Name (First, Middle, Last) <b>AUGUST PAETOW</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>LIDDY CLEMENS</b>			
19a. Informant's Name/Relationship (Type, Print) <b>ARLENE PAETOW</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>328 MOSSY BROOK RD. HIGH FALLS NY 12440</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SALISBURY CREMATORY</b>		20c. Location - City or Town, State <b>10-4 SALISBURY, MD.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>ULLRICH FUNERAL HOME BERLIN, MD. 21811</b>			
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>Acute Myocardial Infarction</b>			Approximate Interval Between Onset and Death <b>Hours</b>
		Due to (or as a consequence of):			
		b. <b>Coronary Artery Disease</b>			<b>Years</b>
		Due to (or as a consequence of):			
		c.			
		Due to (or as a consequence of):			
		d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Valvular Heart Disease</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D 36783</b>		29d. Date signed (Month, Day, Year) <b>10/03/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jeffrey E. Etherington, MD, AGH, Berlin, MD 2811</b>					
31. Date filed (Month, Day, Year) <b>OCT 05 2000</b>		32. Registrar's Signature 			



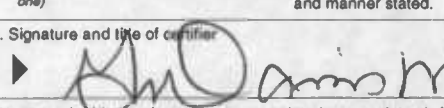
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32848

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Melvin Leonard Powell</b>				2. Date of Death Month <b>OCTOBER</b> Day <b>2nd</b> Year <b>2000</b>		3. Time of Death <b>2:13 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>FRANKLIN SQUARE HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>ROSEDALE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>212-03-8439</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 3, 1914</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
Usual Residence of Decedent								
10a. State <b>MD</b>			10b. County <b>Baltimore</b>			10c. City, Town or Location <b>Baltimore</b>		
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			10e. Street and Number <b>7614 Cedar Rd</b>			10f. Zip Code <b>21222</b>		
10g. Citizen of What Country? <b>United States</b>			11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Crane Operator</b>			16b. Kind of Business/Industry <b>Bethlehem Steel</b>			17. Father's Name (First, Middle, Last) <b>Aleck Powell</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Walley</b>			19a. Informant's Name/Relationship (Type, Print) <b>Leonard Powell / son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7614 Cedar RD. Baltimore, MD 21222</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory, Inc.</b>			20c. Date <b>10/4/00</b>		
20d. Location - City or Town, State <b>Beltsville, MD</b>			21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures DR., Towson, MD 21286</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): <b>ISCHEMIA</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 			29c. License number <b>RD 188821</b>			29d. Date signed (Month, Day, Year) <b>10/2/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>GERRI DAVIS, MD, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237</b>								
31. Date filed (Month, Day, Year) <b>OCT 05 2000</b>			32. Registrar's Signature 					

11/10/12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32849

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DAVID S. PORTNOI

2. Date of Death  
Month Day Year  
OCTOBER 5, 20003. Time of Death  
7:10 AMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

11247 WATERMILL LANE

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

212-04-3776

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
FEB 12, 1912

9. Birthplace (State or Foreign Country)

POLAND

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

SILVER SPRING

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11247 WATERMILL LANE

10f. Zip Code

20902

10g. Citizen of What Country?

BRITAIN

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

BUSINESS OWNER

16b. Kind of Business/Industry

GARMENT MANUFACTURING

17. Father's Name (First, Middle, Last)

ELIYAHU MOSHE PORTNOI

18. Mother's Name (First, Middle, Maiden Surname)

SARAH BEILA SEVITZ

19a. Informant's Name/Relationship (Type, Print)

RONALD KLEINFELD/SON IN LAW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11247 WATERMILL LANE, SILVER SPRING, MARYLAND 20902

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ERETZ HaCHAILM CEMETERY

Date

OCTOBER 6, 2000

20c. Location - City or Town, State

SHAMSHON, ISRAEL

21. Signature of Funeral Service Licensee

Donald C. Stammers

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ARTERIOSCLEROTIC HEART DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Barry Rosenbaum, M.D.

29c. License number

D09834

29d. Date signed (Month, Day, Year)

10/5/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARRY ROSENBAUM 3720 FARRAGUT AVE KENSINGTON, MD 20895

31. Date filed (Month, Day, Year)

OCT 06 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

3





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32850

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RENEE IDA POLLOCK

2. Date of Death

Month Day Year  
Sept 28th 2000

3. Time of Death

7:05 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

178-03-4347

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
7/11/12

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6121 MONTROSE RD.

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12) College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

HARRY GARFINKEL

18. Mother's Name (First, Middle, Maiden Surname)

MINNIE ASOFSKY

19a. Informant's Name/Relationship (Type, Print)

MICHAEL A. POLLOCK / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

440 FAIRWAY RD., RIDGEWOOD, NJ 07450

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CONGREGATION MERCY &amp; HOPE CEMETERY

Date

9/29/00

20c. Location - City or Town, State

POTTSTOWN, PA

21. Signature of Funeral Service Licensee

DANIEL SIMONS

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.  
1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute Cardio-pulmonary arrest  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary artery disease  
Due to (or as a consequence of):c. pneumonia  
Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

osteoporosis contractures (hands)

chronic cerebral ischemic dysphagia

peripheral vascular disease Constipation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Consuelo Martinez

29c. License number

D:44907

29d. Date signed (Month, Day, Year)

Sept 28th 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6121 Montrose Road Rockville MD 20852

31. Date filed (Month, Day, Year)

OCT 06 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32851

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wayne

Poindexter

2. Date of Death

Month Day Year  
Oct. 4, 2000

3. Time of Death

1:11A.

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE

4b. City, Town, or Location of Death

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

136-56-6784

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

43 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
July 26, 1957

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19938 Gateshead Circle

10f. Zip Code

20876

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Claims Adjuster

16b. Kind of Business/Industry

State Farm Ins.

17. Father's Name (First, Middle, Last)

Oscar

Poindexter

Mozell

Jackson

19a. Informant's Name/Relationship (Type, Print)

Paula Verkuilen (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parklawn Memorial Gardens 10/7/00 Rockville, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Donald V. Borgwardt

22. Name and Address of Facility

Donald V. Borgwardt Funeral Home, P.A.  
4400 Powder Mill Rd. Beltsville, Maryland 2070523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiac arrhythmia

Due to (or as a consequence of):

minutes

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

years

c. Atherosclerotic cardiovascular disease

Due to (or as a consequence of):

years

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Patricia L. Tomsko, MD

29c. License number

D51916

29d. Date signed (Month, Day, Year)

October 4, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patricia L. Tomsko, MD, 1140 Rockville Pike, PMB 348, Rockville, MD 20852

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 05 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202.536.1234.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32852  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sean Lea Phillips				2. Date of Death Month Day Year OCTOBER 1, 2000		3. Time of Death 15:20 PM						
	4a. Facility Name (If not institution, give street and number) 80 B BUREAU DRIVE				4b. City, Town, or Location of Death GAITHERSBURG		4c. County of Death MONTGOMERY						
Funeral Director	5. Social Security Number 267-45-9725		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 29 Yrs.		8. Date of Birth (Month, Day, Year) July 6, 1971		9. Birthplace (State or Foreign Country) New Mexico				
	Usual Residence of Decedent												
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 80-B Bureau Drive, Apt. B				10f. Zip Code 20878		10g. Citizen of What Country? USA							
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic			16b. Kind of Business/Industry Automobile						
17. Father's Name (First, Middle, Last) Daniel Wayne Phillips					18. Mother's Name (First, Middle, Maiden Surname) Diane Alice Lea								
19a. Informant's Name/Relationship (Type, Print) Daniel W. Phillips / Father					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1635 Nordic Hill Circle, Silver Spring, MD 20906								
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Crematory 10/06/00			Date 10/06/00		20c. Location - City or Town, State Brentwood, Maryland					
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.  Immediate Cause (Final disease or condition resulting in death) a. Hanging Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) SCENE										
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) Found 10-01-2000		28b. Time of Injury unknown M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred subject hanged self				
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence			28f. Location (Street and Number or Rural Route Number, City or Town, State) 80 B Bureau Drive Montgomery County, Maryland										
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier 							29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) OCTOBER 2, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201													
31. Date filed (Month, Day, Year) OCT 05 2000			32. Registrar's Signature 										

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32853

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Frances Parlon

2. Date of Death

Month Day Year  
September 29, 2000 3:00 am

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Montgomery Hospice - Casey House

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

577-01-7919

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 12, 1916

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14564 Kelmscot Drive

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Samuel Ledford

18. Mother's Name (First, Middle, Maiden Surname)

Margaret E. Wingate

19a. Informant's Name/Relationship (Type, Print)

Bonnie J. Hummer/ Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2405 1/2 20th Street, NW, #101, Washington, DC 20009

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

9/29/00

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

J. Keir Skiles

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd., W, Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cancer of Liver

Due to (or as a consequence of):

18 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

E. P. Libre MD

29c. License number

D 09470

29d. Date signed (Month, Day, Year)

September 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. P. Libre, MD 10400 Connecticut Ave., Kensington, MD 20895

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 6 2 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

penn. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32854

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Dolores Mangrich Palmer				2. Date of Death Month Day Year October 3, 2000		3. Time of Death 810am	
	4a. Facility Name (If not Institution, give street and number) 802 Kenbrook Dr				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 478-12-3800	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan 26, 1922		9. Birthplace (State or Foreign Country) IA
	Usual Residence of Decedent							
10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 802 Kenbrook Dr				10f. Zip Code 20902		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) (UNKNOWN)				18. Mother's Name (First, Middle, Maiden Surname) (UNKNOWN)				
19a. Informant's Name/Relationship (Type, Print) Donald Palmer /Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 Kenbrook Dr, Silver Spring, MD 20902				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Date Oct 5 2000		20c. Location - City or Town, State Beltsville, MD
21. Signature of Funeral Service Licensee Beverly R. Hall				22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Avenue Silver Spring, MD				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Respiratory Failure Due to (or as a consequence of): Chronic obstructive lung disease  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Congestive heart failure coronary artery disease						Approximate Interval Between Onset and Death Weeks Years	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Congestive heart failure coronary artery disease						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Ernest S. Oser M.D.				29c. License number D03792		29d. Date signed (Month, Day, Year) October 03, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ernest S. Oser M.D. 10301 Georgia Ave #304, Silver Spring, MD 20902								
31. Date filed (Month, Day, Year) OCT 04 2000				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



00 32855

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marjorie Marie Ross				2. DATE OF DEATH MONTH DAY YEAR Sept. 29, 2000				3. TIME OF DEATH 6:50 P.M. M							
4. SOCIAL SECURITY NUMBER 214-03-6257		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Mar. 16, 1912		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Mallard Bay Nursing Home						9b. CITY, TOWN OR LOCATION OF DEATH Cambridge				9c. COUNTY OF DEATH Dorchester					
RESIDENCE OF DECEDENT															
10a. STATE Maryland				10b. COUNTY Dorchester				10c. CITY, TOWN OR LOCATION Cambridge				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 520 Glenburn Ave.						10f. ZIP CODE 21613				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Crab Picker				16b. KIND OF BUSINESS/INDUSTRY Seafood							
17. FATHER'S NAME (First, Middle, Last) Wilbert Travers						16. MOTHER'S NAME (First, Middle, Maiden Surname) Susan Johnson									
19a. INFORMANT'S NAME (Type/Print) Brenda Cephas / Neice						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 Boltdsbrough Ave., Cambridge, Maryland 21613									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meekins Neck Cemetery 10/7/2000				20c. LOCATION — City or Town, State Church Creek, Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Decubitus c. Diabetes Mellitus d.												Approximate interval Between Onset and Death days months years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER Mary Ann D. Moore MD						29c. LICENSE NUMBER D31766				29d. DATE SIGNED (Month, Day, Year) 10-5-00					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Mary Ann D. Moore MD, 408 Byron St. Cambridge, Md.															
31. DATE FILED (Month, Day, Year) OCT 05 2000						32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32856

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Diann Gertrude Rochester</b>				2. Date of Death Month Day Year <b>September 28 2000</b>		3. Time of Death <b>2025</b>	
	4a. Facility Name (If not institution, give street and number) <b>The Kent and Queen Anne's Hospital, Inc.</b>				4b. City, Town, or Location of Death <b>Chestertown</b>		4c. County of Death <b>Kent</b>	
Funeral Director	5. Social Security Number <b>219-56-9098</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>49</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 3, 1951</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Queen Annes</b>		10c. City, Town or Location <b>Centreville</b>	
Usual Residence of Decedent		10a. Street and Number <b>107 Holton Street</b>		10f. Zip Code <b>21617</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Line Worker</b>		16b. Kind of Business/Industry <b>Campbell Soup</b>		17. Father's Name (First, Middle, Last) <b>George Copeland Barrett</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Algie Virginia Dodd</b>		19a. Informant's Name/Relationship (Type, Print) <b>Charmonque N. Rochester/Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>107 Holton Street, Centreville, Maryland 21617</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rich Neck Cemetery</b>		20c. Location - City or Town, State <b>10/4/2000 Ewingtown, Maryland</b>		21. Signature of Funeral Service Licensee <b>John A. Prince</b>		22. Name and Address of Facility <b>Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21610</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		e. <b>Anoxic Encephalopathy</b> Due to (or as a consequence of)		f. <b>Cardiopulmonary Arrest</b> Due to (or as a consequence of):		g. <b>Status Asthmaticus</b> Due to (or as a consequence of):		
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>10/4/2000</b>		28b. Time of Injury <b>M</b>		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>John A. Prince, MD</b>		29c. License number <b>021313</b>		29d. Date signed (Month, Day, Year) <b>10/2/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>KIN R. WUN, 415 Washington Ave., Chestertown, MD 21620</b>		31. Date filed (Month, Day, Year) <b>OCT 05 2000</b>		32. Registrar's Signature <b>B. Sparks</b>		33. State Registrar		

ORIGINAL



Milton Roberts

AMEND ITEM 23a, per ME G793 032901 SS  
amend item 23a, 27 per me G788 10/18/00 yf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32857

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Milton Roberts</b>				2. Date of Death Month Day Year <b>September 28, 2000</b>				3. Time of Death <b>8:28 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>226 Dodson Avenue</b>				4b. City, Town, or Location of Death <b>St. Michael's</b>				4c. County of Death <b>Talbot</b>	
Funeral Director	5. Social Security Number <b>unk</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>unk</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth <b>unk</b> (Month, Day, Year)		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>unk</b>		10b. County <b>unk</b>		10c. City, Town or Location <b>unk</b>	
Usual Residence of Decedent										
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
10e. Street and Number <b>unk</b>				10f. Zip Code <b>unk</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <b>unk</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <b>unk</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) <b>unk</b> Elementary/Secondary (0-12) College (1-4or 5+)				16a. Decedent's Usual Occupation <b>unk</b> (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry <b>unk</b>		
17. Father's Name (First, Middle, Last) <b>unk</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>unk</b>				
19a. Informant's Name/Relationship (Type, Print) <b>unk</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>unk</b>				
20a. Method of Disposition <b>unk</b> <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>unk</b>		Date <b>unk</b>		20c. Location - City or Town, State <b>unk</b>		
21. Signature of Funeral Service Licensee						22. Name and Address of Facility <b>Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO RENAL FAILURE ASSOCIATED WITH PNEUMONIA</b>										
Immediate Cause (Final disease or condition resulting in death) <b>a. <del>HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO RENAL DISEASE</del></b> Due to (or as a consequence of):										
b. Due to (or as a consequence of):										
c. Due to (or as a consequence of):										
d. Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b>										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>Haymone McKell</b>						29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 29, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARYDAN A. KOBAN RN 111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>OCT 6 2000</b>										
32. Registrar's Signature <b>B. Sparks</b>										

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32858

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Pennie Ruffin</i>				2. Date of Death Month <i>Sept</i> Day <i>25</i> Year <i>2000</i>		3. Time of Death <i>407AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Howard Co Gen Hospital</i>				4b. City, Town, or Location of Death <i>Columbia</i>		4c. County of Death <i>Howard</i>	
Funeral Director	5. Social Security Number <i>245-42-4562</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>81</i> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>May 21, 1919</i>	
	9. Birthplace (State or Foreign Country) <i>Wilson Co., NC</i>							
To Be Completed by Funeral Director	10a. State <i>MD</i>		10b. County <i>Montgomery</i>		10c. City, Town or Location <i>Silver Spring</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <i>3706 Lamberton Square Road Apt. 153</i>				10f. Zip Code <i>02904</i>		10g. Citizen of What Country? <i>USA</i>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>Black</i>	
	15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>6</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Picker</i>		16b. Kind of Business/Industry <i>Tobacco Exports</i>			
	17. Father's Name (First, Middle, Last) <i>Robert Hilliard</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Pennie Bynum</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Pennie Southerland - Daughter</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3706 Lamberton Square Rd. #153 Silver Spring, MD</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Rest Haven Cemetery</i>		20c. Location - City or Town, State <i>Wilson County, NC</i>		20d. Date <i>10/7/00</i>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <i>Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, VA 22310</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <i>Pulmonary edema</i> Due to (or as a consequence of):</p> <p>b. <i>renal failure</i> Due to (or as a consequence of):</p> <p>c. _____ Due to (or as a consequence of):</p> <p>d. _____ Due to (or as a consequence of):</p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> <p><i>6 hrs</i></p> <p><i>1 year</i></p> </div> </div>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>hypertension</i>							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>D41617</i>		29d. Date signed (Month, Day, Year) <i>Sep 25, 00</i>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Gary Kszewski 10805 Hickory Ridge Rd Columbia Md 21044</i>								
31. Date filed (Month, Day, Year) <i>OCT 04 2000</i>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32859

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Jane Rubin			2. Date of Death Month Day Year October 3, 2000		3. Time of Death 11:30 pm	
	4a. Facility Name (If not institution, give street and number) Forest Glen Skilled Nursing Center			4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 216-82-9265	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 4, 1919	9. Birthplace (State or Foreign Country) DC
	Usual Residence of Decedent						
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number 10012 Portland Place			10f. Zip Code 20901		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Percy R. Rogers				18. Mother's Name (First, Middle, Maiden Surname) Hilda Miller			
19a. Informant's Name/Relationship (Type, Print) Norman N. Rubin/ Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10012 Portland Place, Silver Spring, MD 20901			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park		Date 10/6/00		20c. Location - City or Town, State Rockville, MD	
21. Signature of Funeral Service Licensee <i>James S. Odey</i>				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. Cerebrovascular Infarct Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							Approximate Interval Between Onset and Death 24 hours
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Phillip W. Poth, M.D.</i>		29c. License number D22309		29d. Date signed (Month, Day, Year) October 4, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Phillip W. Poth, MD 9013 Flower Ave., Silver Spring, MD 20901							
31. Date filed (Month, Day, Year) OCT 05 2000		32. Registrar's Signature <i>B. Sparks</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32860

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen Roshak</b>				2. Date of Death Month <b>September</b> Day <b>28</b> Year <b>2000</b>				3. Time of Death <b>7:20 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>3501 Forsythia Lane</b>				4b. City, Town, or Location of Death <b>Burtonsville</b>				4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>204-09-9457</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>86</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 6, 1914</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>	
	10a. State <b>Maryland</b>				10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Burtonsville</b>			
To Be Completed by Funeral Director	10d. Inside City Limits <b>1 Yes 2 No</b>				10e. Street and Number <b>3501 Forsythia Lane</b>				10f. Zip Code <b>20866</b>	
	10g. Citizen of What Country? <b>United States</b>				11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>				12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 No</b>				14. Race - American Indian, Black, White, etc. <b>Specify: White</b>				15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10 College (1-4 or 5+)</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Seamstress</b>				16b. Kind of Business/Industry <b>Garment</b>				17. Father's Name (First, Middle, Last) <b>Michael Kutch</b>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>Kathryn Petrillak</b>				19a. Informant's Name/Relationship (Type, Print) <b>Ellen Barber/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3501 Forsythia Lane Burtonsville, MD 20866</b>	
	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Michael Church Cem.</b>				20c. Location - City or Town, State <b>10/02/00 Jermyn, PA</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Anthony S. D. My</b>				22. Name and Address of Facility <b>Hines-Rinaldi Funeral Home, Inc.</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Respiratory Compromise from Lung Collapse</b>	
	23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>				24a. Was an autopsy performed? <b>1 Yes 2 No</b>				24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <b>1 Yes 2 No</b>				26. Place of Death (Check only one) <b>Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)</b>				27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>	
	28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No</b>				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>				29b. Signature and title of certifier <b>Linda M. Burrell</b>				29c. License number <b>D35996</b>	
	29d. Date signed (Month, Day, Year) <b>Sept. 29, 2000</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Linda Burrell, MD 2730 University Blvd. #400 Silver Spring, MD 20902</b>				31. Date filed (Month, Day, Year) <b>OCT 02 2000</b>	
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <b>B. Sparks</b>				33. Date of Death (Month, Day, Year) <b>September 28, 2000</b>				34. Time of Death <b>7:20 PM</b>	
	35. Signature of Funeral Service Licensee <b>Anthony S. D. My</b>				36. Name and Address of Facility <b>Hines-Rinaldi Funeral Home, Inc.</b>				37. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3501 Forsythia Lane Burtonsville, MD 20866</b>	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32861

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elba Roca				2. Date of Death Month Day Year October 1, 2000				3. Time of Death 100am				
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery				
Funeral Director	5. Social Security Number 213-76-6349		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 55 Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) Mar 29, 1945		9. Birthplace (State or Foreign Country) Bolivia		
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State MD		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
	10e. Street and Number 14136 Whispering Pines Ct. #13				10f. Zip Code 20906		10g. Citizen of What Country? United States						
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: South American				14. Race - American Indian, Black, White, etc. Specify: Hispanic				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home				
	17. Father's Name (First, Middle, Last) Nestor Roca				18. Mother's Name (First, Middle, Maiden Surname) Sada Salinas								
	19a. Informant's Name/Relationship (Type, Print) Maria Ozeki / Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11215 Oakleaf Dr #1712, Silver Spring, MD 20901								
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory		Data Oct 4 2000		20c. Location - City or Town, State Beltsville, MD						
	21. Signature of Funeral Service Licensee Beverly L. Holt				22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Avenue Silver Spring, MD								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Non-Hodgkins Lymphoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death 2 years		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier Frederick G. Barr M.D.				29c. License number D22775				29d. Date signed (Month, Day, Year) October 02, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick G. Barr M.D. 2101 Medical Park Dr., Suite 210, Silver Spring 20902													
State Registrar		31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature B. Sparks									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32862

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Fidel Del Rio				2. Date of Death Month Day Year September 29, 2000		3. Time of Death 3:55AM	
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 577-92-0095		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 71 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 10, 1929	
	9. Birthplace (State or Foreign Country) Spain		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Chevy Chase	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number 4210 East-West Highway		10f. Zip Code 20815	
	10g. Citizen of What Country? Spain				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No Specify: Spanish				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Gardener				16b. Kind of Business/Industry Embassy of Switzerland		17. Father's Name (First, Middle, Last) Not Available	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Summa) Manuela Del Rio				19a. Informant's Name/Relationship (Type, Print) Avelina Del Rio/Wife		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4210 East-West Highway, Chevy Chase, Maryland 20815	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		20c. Location - City or Town, State Bethesda, Maryland	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee D. E. Perry M00803				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CARDIAC ARREST Due to (or as a consequence of): b. ISCHEMIC CARDIOPATHY Due to (or as a consequence of): c. PHARYNX CARCINOMA Due to (or as a consequence of): d. CHRONIC OBSTRUCTIVE BRONCHITIS / SILENUS Approximate Interval Between Onset and Death MINUTES YEARS MONTHS YEARS				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	29b. Signature and title of certifier J. A. Quiros M.D.				29c. License number D29256			
To Be Completed by Physician/Medical Examiner	29d. Data signed (Month, Day, Year) 09/29/00				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSE A. QUIROS M.D. 4343 MONTGOMERY AV BETHESDA MD 20814			
	31. Data filed (Month, Day, Year) OCT 02 2000				32. Registrar's Signature B. Sparks			

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 32863

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Homer L. Reighard

2. Date of Death

October 1, 2000

3. Time of Death

8:50 pm

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

188-20-7020

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

December 1, 1924

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10215 Hatherleigh Drive

10f. Zip Code

20814-2223

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: Korea13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Physician

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

David F. Reighard

18. Mother's Name (First, Middle, Maiden Surname)

Cora Steel

19a. Informant's Name/Relationship (Type, Print)

Barbara S. Reighard / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10215 Hatherleigh Drive Bethesda, Maryland 20814

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)Montgomery  
Crematorium Inc.

Date

October  
3, 2000

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00335

22. Name and Address of Facility

Robert A. Humphrey Funeral Home/  
Bethesda-Chevy Chase Inc. 7557 Wisconsin Avenue  
Bethesda, Maryland 20814-350123a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Congestive heart failure

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

4 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Coronary artery disease

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee R. Pennington, M.D. 10215 Fernwood Rd., Bethesda, MD 20817

31. Date filed (Month, Day, Year)

OCT 06 2000

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15+1

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 32864

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lucille Robinson

2. Date of Death

Month Day Year  
9 28 00

3. Time of Death

8:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

608 B. South Westover Drive

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

5. Social Security Number

134-22-2763

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar. 8 1926

9. Birthplace (State or Foreign Country)

N. Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

608 B South Westover Drive

10f. Zip Code

21801

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Joe Davis

18. Mother's Name (First, Middle, Maiden Summa)

Dora Davis

19a. Informant's Name/Relationship (Type, Print)

Gail Jones (Granddaughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

62 Sandy Dr. Millsboro, DE 19966

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Springhill Mem. Garden

Date

10/3/00

20c. Location - City or Town, State

Hebron, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Stewart Funeral Home

821 West Rd. Salisbury, Md. 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Atherosclerotic Cardiovascular Dr.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

&gt; 20 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin Dependent Diabetes mellitus

Atrial Fibrillation

Renal Insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

024986

29d. Date signed (Month, Day, Year)

10/2/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert J. Ratty MD 560 Riverside Dr B101 Salisbury Md. 21801

31. Date filed (Month, Day, Year)

OCT 02 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

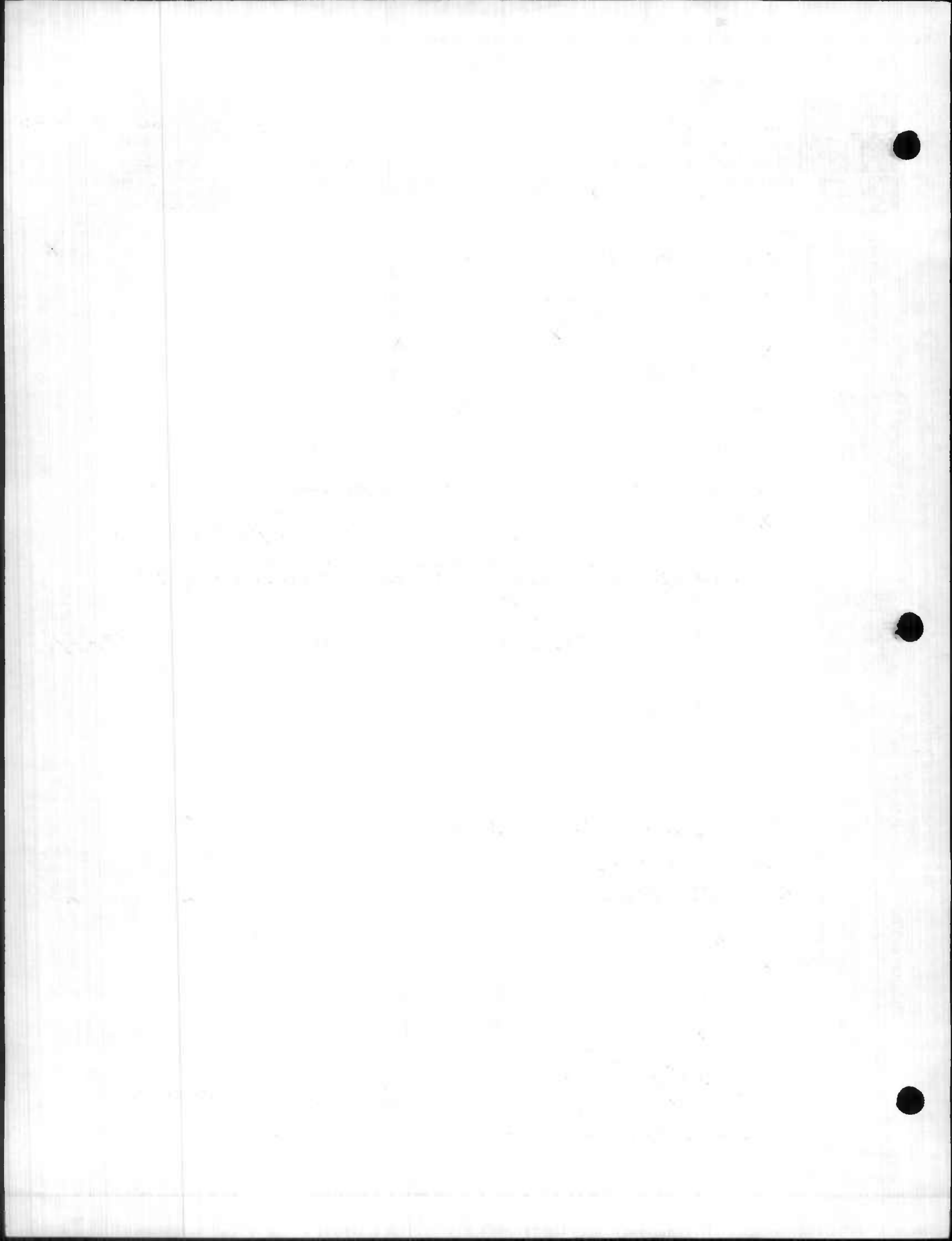
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene

00 32865

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Louise E. Reed

2. Date of Death

Month Day Year  
October 12, 2000

3. Time of Death

11:30AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Mariner Health of Kensington

4b. City, Town, or Location of Death

Kensington

4c. County of Death

Montgomery

5. Social Security Number

220-24-2365

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 11, 1908

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD.

10b. County

Montgomery

10c. City, Town or Location

Kensington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3000 McComas Avenue

10f. Zip Code

20895

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Frank S. Royston

18. Mother's Name (First, Middle, Maiden Surname)

Lula Peyton

19a. Informant's Name/Relationship (Type, Print)

Louise Dell / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8532 Storch Woods Drive #2A Savage, Md. 20763

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

Oct 16 2000

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

G. S. K. / M00770

22. Name and Address of Facility

Donaldson Funeral Home, P.A.

313 Talbott Avenue, Laurel, MD 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dehydration

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Daphna Henkin

29c. License number

D00053528

29d. Date signed (Month, Day, Year)

October 13, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daphna Henkin, MD 2309 Shorefield Road, Wheaton, MD 20902

31. Date filed (Month, Day, Year)

OCT 13 2000

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32866

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ellis Edward Shrieves Jr.</b>				2. Date of Death Month Day Year <b>September 26, 2000</b>		3. Time of Death <b>2:00 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Salisbury Center; Genesis ElderCare</b>				4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>231-42-8222</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>8-16-36</b>		9. Birthplace (State or Foreign Country) <b>VA.</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Worcester</b>	10c. City, Town or Location <b>Pocomoke</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>110 6th Street</b>				10f. Zip Code <b>21851</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>House Keeping</b>			16b. Kind of Business/Industry <b>College</b>		
	17. Father's Name (First, Middle, Last) <b>Ellis Shrieves Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Tobitha Bailey</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Mayola Matthews (Friend)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>110 6th Street Pocomoke City, Md. 21851</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>First Baptist Cemetery</b>		20c. Location - City or Town, State <b>9-30-01 Mappsville, Va.</b>		20d. Date	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Bennie Smith Funeral Home P.O. Box 331 Pocomoke Md. 21851</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Pneumonia + Sepsis</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
26. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		27a. Date of Injury (Month, Day Year)		27b. Time of Injury M		27c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		27d. Describe how injury occurred
28a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28b. Date of Injury (Month, Day Year)		28c. Time of Injury M		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Signature and title of certifier 		29b. License number <b>D 39813</b>		29c. Date signed (Month, Day, Year) <b>9/27/00</b>		29d. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MICHAEL ATKINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD 21804</b>		
30. State Registrar <b>OCT 02 2000</b>		31. Registrar's Signature 						

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 32867

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES RALPH SHARPE</b>				2. Date of Death Month <b>SEPT</b> Day <b>28</b> Year <b>2000</b>		3. Time of Death <b>5:15 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>TALBOT HOSPICE HOUSE</b>				4b. City, Town, or Location of Death <b>EASTON</b>		4c. County of Death <b>TALBOT</b>		
Funeral Director	5. Social Security Number <b>280-24-9356</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>APR. 15, 1929</b>		
	9. Birthplace (State or Foreign Country) <b>OHIO</b>		10a. State <b>MD</b>		10b. County <b>TALBOT</b>		10c. City, Town or Location <b>OXFORD</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>201 WILSON ST.</b>		10f. Zip Code <b>21654</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>KOREAN</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>5</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CIVIL ENGINEER</b>		16b. Kind of Business/Industry <b>HEAVY CONSTRUCTION</b>		17. Father's Name (First, Middle, Last) <b>LESLIE PURKIS SHARPE</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MARION FRANCES HALL</b>	
19a. Informant's Name/Relationship (Type, Print) <b>SALLY K. SHARPE/ WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 363, OXFORD, MD 21654</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHESAPEAKE CREMATION CTR</b>		20c. Location - City or Town, State <b>9-29-2000 STEVENSVILLE, MD</b>	
21. Signature of Funeral Service Licensee <i>M. J. Newnam</i> CFSP		22. Name and Address of Facility <b>FELLOWS, HELFENBEIN &amp; NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Chronic myelomonocytic leukemia</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death <b>10 1/2 months</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Hospice House</b>		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D39887</b>		29d. Date signed (Month, Day, Year) <b>9/29/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAVID H. SMITH, M.D., 29486 PINTAIL DRIVE, EASTON, MD 21601</b>		31. Date filed (Month, Day, Year) <b>OCT 02 2000</b>		32. Registrar's Signature <i>[Signature]</i>					

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State of Maryland / Department of Health and Mental Hygiene

00 32868

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALYCE MARIE SUNDT</b>				2. Date of Death Month Day Year <b>October 3 2000</b>		3. Time of Death <b>2:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Genesis ElderCare - The Pines</b>				4b. City, Town, or Location of Death <b>Easton</b>		4c. County of Death <b>Talbot</b>	
Funeral Director	5. Social Security Number <b>348-30-0053</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 17, 1915</b>		9. Birthplace (State or Foreign Country) <b>Wisconsin</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Talbot</b>		10c. City, Town or Location <b>St. Michaels</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number <b>932 Riverview Terrace</b>				10f. Zip Code <b>21663</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Home</b>	
17. Father's Name (First, Middle, Last) <b>Adolph Sannes</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Aagot Imingen</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Gary P. Sundt Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>932 Riverview Terrace St. Michaels, Maryland 21663</b>				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Capitol Crematory Oct. 4, 2000</b>		20c. Location - City or Town, State <b>Dover, Delaware</b>		
21. Signature of Funeral Service Licensee <i>Harrison E. Leonard</i>				22. Name and Address of Facility <b>Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>CHRONIC URINARY TRACT INFECTION</b>								Approximate Interval Between Onset and Death <b>YEARS</b> <b>YEARS</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC URINARY TRACT INFECTION</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>W.B. Bremer MD</i>				29c. License number <b>D26350</b>		29d. Date signed (Month, Day, Year) <b>10/3/2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William S. Bremer M.D. 800 S. Talbot St. St. Michaels, Maryland 21663</b>								
31. Date filed (Month, Day, Year) <b>OCT 06 2000</b>		32. Registrar's Signature <i>Benita B. Sparks</i>						

Alyce Sundt

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: if item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0066.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene 00 32869

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Catherine Cecil Stull</b>				2. Date of Death Month Day Year <b>October 2, 2000</b>		3. Time of Death <b>5:40 PM</b>																	
	4a. Facility Name (If not institution, give street and number) <b>Montgomery Hospice Casey House in Rockville</b>				4b. City, Town, or Location of Death <b>Rockville</b>		4c. County of Death <b>Montgomery</b>																	
Funeral Director	5. Social Security Number <b>359-03-5094</b>	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 9, 1921</b>		9. Birthplace (State or Foreign Country) <b>Minnesota</b>																
	Usual Residence of Decedent																							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																		
10e. Street and Number <b>7505 Democracy Blvd., #A116</b>				10f. Zip Code <b>20817</b>		10g. Citizen of What Country? <b>United States</b>																		
11. Mental Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrative Assistant</b>		16b. Kind of Business/Industry <b>National Institutes of Health</b>																		
17. Father's Name (First, Middle, Last) <b>Everett Cecil</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Meda Hayes</b>																				
19a. Informant's Name/Relationship (Type, Print) <b>Constance S. Quinn/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9708 Ashbourn Drive, Burke, Virginia 22015</b>																				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>																		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.</b> <b>M00846 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>																				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																								
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Lung Cancer</b></td> <td>3 Months</td> </tr> <tr> <td colspan="3">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td colspan="3"></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	<b>Lung Cancer</b>	3 Months	Due to (or as a consequence of):			b.	Due to (or as a consequence of):		c.	Due to (or as a consequence of):		d.			
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a.	<b>Lung Cancer</b>	3 Months																					
	Due to (or as a consequence of):																							
	b.	Due to (or as a consequence of):																						
	c.	Due to (or as a consequence of):																						
d.																								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Parkinson's Disease</b> <b>Cerebrovascular Accident (Stroke)</b>						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																		
						24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>																				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred																				
28f. Location (Street and Number or Rural Route Number, City or Town, State)																								
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																								
29b. Signature and title of certifier <i>E. P. Libre M.D.</i>				29c. License number <b>D09470</b>		29d. Date signed (Month, Day, Year) <b>October 2, 2000</b>																		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Eugene P. Libre, M.D., 10400 Connecticut Avenue, Kensington, Maryland 20895</b>																								
31. Date filed (Month, Day, Year) <b>OCT 04 2000</b>				32. Registrar's Signature <i>[Signature]</i>																				



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State of Maryland / Department of Health and Mental Hygiene

00 32870

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Adele J. Street				2. Date of Death Month Day Year October 1, 2000		3. Time of Death 9:52 pm	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 216-14-4369		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) Oct 26, 1916	
	9. Birthplace (State or Foreign Country) New Jersey		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 9101 2nd Avenue		10f. Zip Code 20910		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Clerk		16b. Kind of Business/Industry N.O.A.A. Federal Government				
17. Father's Name (First, Middle, Last) Emmanuel DeCarlo				18. Mother's Name (First, Middle, Maiden Surname) Johanna Jamele				
19a. Informant's Name/Relationship (Type, Print) Anthony J. Street/ Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5641 Columbia Road, #301, Columbia, MD 21044				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Date 10/5/00		20d. Location - City or Town, State Silver Spring, MD		
21. Signature of Funeral Service Licensee Andrew J. Cole				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Embolism Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death 1 day								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Anurita Mendhiratta MD				29c. License number D 38262		29d. Date signed (Month, Day, Year) October 2, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anurita Mendhiratta, MD 2401 Research Blvd., Suite 340, Rockville, MD 20854								
31. Date filed (Month, Day, Year) OCT 03 2000				32. Registrar's Signature B. Sparks				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32871

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BELLE HELEN STANLEY

2. Date of Death

Month Day Year  
SEPT. 29 2000

3. Time of Death

10:05 AM

4a. Facility Name (If not institution, give street and number)

5901 MONTROSE RD. #C301

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

578-01-6142

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

DEC. 1 1911

9. Birthplace (State or Foreign Country)

INAN, PA

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

5901 MONTROSE RD. #C301

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

EXEC. SECRETARY

16b. Kind of Business/Industry

LAW OFFICE

17. Father's Name (First, Middle, Last)

LOUIS F. MYERS

18. Mother's Name (First, Middle, Maiden Surname)

FRIEDA R. BUCKANTZ

19a. Informant's Name/Relationship (Type, Print)

MARC STANLEY/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1083 PIPESTEM PLACE, ROCKVILLE, MD 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

JUDEAN MEMORIAL GARDENS

Date

SEPT 02, 2000

20c. Location - City or Town, State

OLNEY, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE MYELOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D07285

29d. Date signed (Month, Day, Year)

SEPTEMBER 29, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JAMES A. BROWN, MD 9707 MEDICAL CENTER DRIVE, ROCKVILLE, MD 20850

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 03 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32872

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Louise B. Sprinkle</b>				2. Date of Death Month <b>September</b> Day <b>25</b> Year <b>2000</b>				3. Time of Death <b>8:30PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Mariner Health Care of Bethesda</b>				4b. City, Town, or Location of Death <b>Bethesda</b>				4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>251-18-4052</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 6, 1918</b>		9. Birthplace (State or Foreign Country) <b>North Carolina</b>	
Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Chevy Chase</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>7104 Meadow Lane</b>				10f. Zip Code <b>20815</b>		10g. Citizen of What Country? <b>United States</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>James O. Belton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Jane Hawks</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Charles Duke Brannock/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7104 Meadow Lane, Chevy Chase, Maryland 20815</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oak Grove Cemetery</b>		Date <b>Sept 30 2000</b>		20c. Location - City or Town, State <b>North Carolina</b>			
21. Signature of Funeral Service Licensee  M00803				22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814-3501</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Respiratory Arrest</b> Due to (or as a consequence of):  b. <b>Recurrent Aspiration Pneumonia</b> Due to (or as a consequence of):  c. <b>Chronic Obstructive Pulmonary Disease</b> Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death  <b>5-10 Minutes</b>  <b>6 Months</b>  <b>Years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 		29c. License number <b>D19609</b>		29d. Date signed (Month, Day, Year) <b>September 26, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Raman R. Tuli, M.D. 10810 Darnestown Road, #202, Gaithersburg, MD 20878</b>									
31. Date filed (Month, Day, Year) <b>OCT 02 2000</b>				32. Registrar's Signature 					

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32873

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lois Douglas Weaver Spinks</b>				2. Date of Death Month Day Year <b>October 4, 2000</b>		3. Time of Death <b>1620</b>	
	4a. Facility Name (If not Institution, give street and number) <b>Suburban Hospital</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>215-12-9513</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>84</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 6, 1916</b>		9. Birthplace (State or Foreign Country) <b>Michigan</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Rockville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>11505 Farmland Drive</b>				10f. Zip Code <b>20852</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Administrative Assistant</b>		16b. Kind of Business/Industry <b>National Symphony Orchestra</b>		
17. Father's Name (First, Middle, Last) <b>Frank Lloyd Weaver</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lois Campbell Douglas</b>				
19a. Informant's Name/Relationship (Type, Print) <b>James W. Spinks/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9773 Good Luck Road, #8, Seabrook, Maryland 20706</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Montgomery Crematorium, Inc.</b>		Date <b>Oct 6</b>		20c. Location - City or Town, State <b>Bethesda, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Robert A. Pumfrey</b> M00803				22. Name and Address of Facility <b>Robert A. Pumfrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
Immediate Cause (Final disease or condition resulting in death)		a. <b>Irreversible Congestive heart failure</b>					Approximate Interval Between Onset and Death <b>2 months</b>	
		Due to (or as a consequence of):						
		b. <b>Arteriosclerotic Cardiovascular disease</b>					<b>Several years</b>	
		Due to (or as a consequence of):						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		c.						
		Due to (or as a consequence of):						
		d.						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how Injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>James E. Wilson, MD</b>				29c. License number <b>D23392 Maryland</b>		29d. Date signed (Month, Day, Year) <b>October 4, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James E. Wilson, Jr. MD, 11125 Rockville Pike, Rockville, Maryland 20852</b>								
31. Date filed (Month, Day, Year) <b>OCT 06 2000</b>		32. Registrar's Signature <b>B. Sparks</b>						

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 32874

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROY E. SMITH</b>				2. Date of Death Month <b>September</b> Day <b>30</b> Year <b>2000</b>		3. Time of Death <b>11:15 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Stella Maris Hospice-Mercy</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>237-34-7614</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 01, 1924</b>	
	9. Birthplace (State or Foreign Country) <b>North Carolina</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>1 W. Conway Street #1110</b>		10f. Zip Code <b>21201</b>	
	10g. Citizen of What Country? <b>United States</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Insurance Collector</b>				16b. Kind of Business/Industry <b>Insurance Agency</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Bennet Alexander Smith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Bessie Truberger</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Robert Smith / Brother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>818 Church Street Kings Mountain, NC 28086</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Anatomic Gift Foundation</b>			
	20c. Location - City or Town, State <b>Laurel, Maryland</b>				21. Signature of Funeral Service Licensee <b>[Signature]</b>			
To Be Completed by Physician/Medical Examiner	22. Name and Address of Facility <b>Anatomic Gift Foundation</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Lung Cancer</b>			
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive pulmonary disease</b> <b>Atrial fibrillation</b>			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year) <b>10/2/00</b>			
	28b. Time of Injury <b>M</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>[Signature] MD</b>			
To Be Completed by Physician/Medical Examiner	29c. License number <b>038675</b>				29d. Date signed (Month, Day, Year) <b>10/2/00</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JDE MESHULAM 301 ST PAUL PL SUITE 605 BALTIMORE MD 21202</b>				31. Date filed (Month, Day, Year) <b>OCT 04 2000</b>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <b>[Signature]</b>				33. State Registrar <b>MD</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32875

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SHERYL SHERMAN				2. Date of Death Month Day Year OCTOBER 3, 2000		3. Time of Death 5:30 PM	
	4a. Facility Name (If not institution, give street and number) BEDFORD COURT NURSING HOME				4b. City, Town, or Location of Death SILVER SPRING		4c. County of Death MONTGOMERY	
Funeral Director	5. Social Security Number 272-10-1679		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		8. Date of Birth (Month, Day, Year) 06-12-1912	
	9. Birthplace (State or Foreign Country) OHIO		10a. State MD		10b. County MONTGOMERY		10c. City, Town or Location SILVER SPRING	
Usual Residence of Decedent								
10a. Street and Number 3700 INTERNATIONAL DRIVE				10f. Zip Code 20906		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4) 5+ 2			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SEAMSTRESS			16b. Kind of Business/Industry TAILORING		
17. Father's Name (First, Middle, Last) BENJAMIN DOLINSKY					18. Mother's Name (First, Middle, Maiden Sumama) ANNA KOBITZINK			
19a. Informant's Name/Relationship (Type, Print) AILEEN GOLDMAN/DAUGHTER					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17024 CASHELL ROAD, ROCKVILLE, MARYLAND 20853-1011			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) MT. OLIVE CEMETERY		Data OCT 5, 2000		20c. Location - City or Town, State OLON, OHIO	
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. SENILE DEMENTIA Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death years.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28d. Describe how injury occurred			
28e. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 					29c. License number D38457		29d. Date signed (Month, Day, Year) OCTOBER 4, 2000	
30. Name and address of person who completed cause of death (from 23a) (Type, Print) Nukul Goyar 3001 INTERNATIONAL DR #211, S. SPRING, MD 20906								
31. Date filed (Month, Day, Year) OCT 06 2000			32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32876

Amend #7, 10/5/2000, BMW, Montg. Co.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LAWFORD SHAW</b>				2. Date of Death Month Day Year <b>September 30 2000</b>		3. Time of Death <b>2053</b>		
	4a. Facility Name (If not institution, give street and number) <b>Laurel Regional Hospital</b>				4b. City, Town, or Location of Death <b>Laurel</b>		4c. County of Death <b>Prince George's</b>		
Funeral Director	5. Social Security Number <b>267-52-7038</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> 81 Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 12, 1919</b>		
	9. Birthplace (State or Foreign) <b>JAMAICA</b>		10a. State <b>MD</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>SILVER SPRING</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>11814 IDLEWOOD ROAD</b>		10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>FARMER</b>		16b. Kind of Business/Industry <b>N/A</b>		17. Father's Name (First, Middle, Last) <b>SAMUEL SHAW</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MATILDA BARNETT</b>	
19e. Informant's Name/Relationship (Type, Print) <b>FESTUS SHAW (SON)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11814 IDLEWOOD RD. SILVER SPRING, MD. 20906</b>		20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MADRAS FAMILY PLOT. 10/14/00ST. ANNS, JAMAICA</b>		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>AUSTIN ROYSTER FUNERAL HOME 3821 14TH ST. N.W. WASH, DC. 20011</b>		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Salvador Sylvester, DO</b>		29c. License number <b>H0055927</b>		29d. Date signed (Month, Day, Year) <b>October 2, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland 20785</b>	
31. Date filed (Month, Day, Year) <b>OCT 05 2000</b>		32. Registrar's Signature <i>[Signature]</i>		State Registrar		Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32877

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Howard J. Sharon				2. Date of Death Month Day Year October 1, 2000		3. Time of Death 8:10 PM																														
	4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda		4c. County of Death Montgomery																														
Funeral Director	5. Social Security Number 108-16-6224		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 25, 1914																														
	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Bethesda		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																														
To Be Completed by Funeral Director	10e. Street and Number 7213 Millwood Road				10f. Zip Code 20817		10g. Citizen of What Country? United States																														
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WW II		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Director of Reports & Statistics Administration		16b. Kind of Business/Industry Veterans Administration																																
	17. Father's Name (First, Middle, Last) Michael D. Sharon				18. Mother's Name (First, Middle, Maiden Surname) Mary McCormick																																
	19a. Informant's Name/Relationship (Type, Print) Marie G. Sharon/Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7213 Millwood Road, Bethesda, Maryland 20817																																
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		Date Oct. 4, 2000		20c. Location - City or Town, State Bethesda, Maryland																														
	21. Signature of Funeral Service Licensee  M00198		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501																																		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																				
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="6">a. Gastrointestinal Bleeding</td> <td>Approximate Interval Between Onset and Death 1 day</td> </tr> <tr> <td colspan="6">Due to (or as a consequence of): Esophageal Cancer</td> <td>1 year</td> </tr> <tr> <td colspan="6">b. Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="6">c. Due to (or as a consequence of):</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. Gastrointestinal Bleeding						Approximate Interval Between Onset and Death 1 day	Due to (or as a consequence of): Esophageal Cancer						1 year	b. Due to (or as a consequence of):							c. Due to (or as a consequence of):						
	Immediate Cause (Final disease or condition resulting in death)	a. Gastrointestinal Bleeding						Approximate Interval Between Onset and Death 1 day																													
Due to (or as a consequence of): Esophageal Cancer						1 year																															
b. Due to (or as a consequence of):																																					
c. Due to (or as a consequence of):																																					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																																					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																					
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																														
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred																																		
	28f. Location (Street and Number or Rural Route Number, City or Town, State)																																				
	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																				
State Registrar	29b. Signature and title of certifier 2011 				29c. License number D43083		29d. Date signed (Month, Day, Year) October 3, 2000																														
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George A. Sotos, M.D. 9707 Medical Center Drive, Rockville, Maryland 20850																																				
31. Date filed (Month, Day, Year) OCT 06 2000				32. Registrar's Signature 																																	

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State of Maryland / Department of Health and Mental Hygiene

00 32878

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Elizabeth Barnett Sette</b>				2. Date of Death Month Day Year <b>Sept. 25, 2000</b>		3. Time of Death <b>3:30 AM.</b>	
	4a. Facility Name (If not institution, give street and number) <b>6017 Madawaska Road</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>579-16-9086</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 20, 1913</b>	
	9. Birthplace (State or Foreign Country) <b>New York</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>6017 Madawaska Road</b>		10f. Zip Code <b>20816</b>		
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Managing Editor</b>		16b. Kind of Business/Industry <b>Federal Reserve Board</b>		
17. Father's Name (First, Middle, Last) <b>Benjamin Franklin Barnett</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Jessie Cantrell</b>				
19a. Informant's Name/Relationship (Type, Print) <b>J. Laurence Kent (Trustee)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6259 Executive Board Rockville, MD 20852</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>National Memorial Park</b>		20c. Location - City or Town, State <b>09/27 Falls Church, VA</b>		21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility <b>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW., Washington, D.C. 20016</b>		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Pneumonia</b> Due to (or as a consequence of):  b. <b>Aspiration of Oral Contents</b> Due to (or as a consequence of):  c. <b>Parkinson Disease</b> Due to (or as a consequence of):  d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death  <b>1 Month</b>  <b>6 Months</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebral Vascular Disease</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>DC6104</b>		29d. Date signed (Month, Day, Year) <b>September 25, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Thomas C. Havell, MD. 4201 Cathedral Ave. NW., Washington, D.C. 20016-4901</b>								
31. Date filed (Month, Day, Year) <b>OCT 02 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

32879

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Margaret Isabel Schoeppach</b>				2. Date of Death Month Day Year <b>September 25, 2000</b>				3. Time of Death <b>8:30 am</b>		
	4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Takoma Park</b>				4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>373-32-0348</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug 15, 1913</b>		9. Birthplace (State or Foreign Country) <b>Canada</b>		
	10a. State <b>Maryland</b>				10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Takoma Park</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>1 Austin Place</b>				10f. Zip Code <b>20912</b>				10g. Citizen of What Country? <b>USA</b>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse</b>				16b. Kind of Business/Industry <b>Medical</b>			
17. Father's Name (First, Middle, Last) <b>Walter Coxworth</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Isabel McLennen</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Joyce A. Schoeppach / Daughter</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 Austin Place, Takoma Park, MD 20912</b>					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sunset Hills Association</b>				20c. Location - City or Town, State <b>9/28/00 Flint, MI</b>			
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. <b>Congestive heart failure days</b> Due to (or as a consequence of): b. <b>Chronic End Stage Renal Disease year</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 						29c. License number <b>D 11929</b>		29d. Date signed (Month, Day, Year) <b>09 26 00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David Kessler 7610 Carroll Ave., Takoma Park, MD 20912</b>											
31. Date filed (Month, Day, Year) <b>OCT 03 2000</b>				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32880

## Certificate of Death

Reg. No.

AMEND#3 PER F.H. G788 10-30-2000 JAB

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HANS SCHAEFFER</b>		2. Date of Death Month Day Year <b>OCTOBER 4, 2000</b>		3. Time of Death AM PM <b>1:45 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>9707 OLD GEORGETOWN ROAD #2317</b>		4b. City, Town, or Location of Death <b>BETHESDA</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>156-22-1369</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>MAY 19, 1917</b>
	9. Birthplace (State or Foreign Country) <b>AUSTRIA</b>					
Usual Residence of Decedent						
10a. State <b>MD</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>BETHESDA</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>9707 OLD GEORGETOWN ROAD #2317</b>			10f. Zip Code <b>20814</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CHEMIST</b>		16b. Kind of Business/Industry <b>PHARMACEUTICAL</b>		
17. Father's Name (First, Middle, Last) <b>EMIL SCHAEFFER</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>KAROLINE KOHLMANN</b>			
19a. Informant's Name/Relationship (Type, Print) <b>LILLO SCHAEFFER/WIFE</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9707 OLD GEORGETOWN ROAD #2317, BETHESDA, MD 20814</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>JUDEAN MEMORIAL GARDENS</b>		Date <b>OCT 6, 2000</b>	20c. Location - City or Town, State <b>OLNEY, MARYLAND</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier 		29c. License number <b>026259</b>		29d. Date signed (Month, Day, Year) <b>10/5/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>AVA A KAUFMAN, MD 4930 DEL RAY, BETHESDA</b>						
31. Date filed (Month, Day, Year) <b>OCT 06 2000</b>		32. Registrar's Signature 				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32881

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HARRY VERNON SCHNEIDER

2. Date of Death

Month Day Year  
OCT. 3, 2000

3. Time of Death

9:30 AM

4a. Facility Name (If not institution, give street and number)

SALISBURY CENTER: GENESIS ELDERCARE

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

215-12-3704

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 30, 1914

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Sharptown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

507 Railway

10f. Zip Code

21861

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:Army/  
AirForce13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
216a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Systems Analyst

16b. Kind of Business/Industry

Baltimore Gas &amp; Electric

17. Father's Name (First, Middle, Last)

Louis Schneider

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Schreiber

19a. Informant's Name/Relationship (Type, Print)

Louise T. Schneider/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 492, Sharptown, MD 21861

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Salisbury Crematory

Date

10/4/00

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

Keith R. Bremer

22. Name and Address of Facility

Holloway Funeral Home Professional Association  
501 Snow Hill Rd., Salisbury, MD 2180423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause of each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Alzheimer's Disease*  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

yrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. *coronary artery disease*  
Due to (or as a consequence of):

yrs

c. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner:

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William Robins

29c. License number

029349

29d. Date signed (Month, Day, Year)

10/4/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Robins

1104 HEALTHWAY DR., SALISBURY, Md.

21804

31. Date filed (Month, Day, Year)

OCT 04 2000

32. Registrar's Signature

G. Sparks

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

SCHNEIDER, HARRY VERNON

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit5 mp  
1 VA



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32882

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Minh Vinh Tran				2. Date of Death Month Day Year October 2, 2000				3. Time of Death 5:15 am		
	4a. Facility Name (If not institution, give street and number) Mariner Health Care- Silver Spring				4b. City, Town, or Location of Death Silver Spring				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 216-98-7315		8. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	15a. State Maryland		15b. County Montgomery		15c. City, Town or Location Silver Spring		15d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		15e. Street and Number 106 East Wayne Avenue		
15f. Zip Code 20901		15g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Asian	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Businessman				16b. Kind of Business/Industry Retail Sales			
17. Father's Name (First, Middle, Last) Than Tran				18. Mother's Name (First, Middle, Maiden Surname) Nhan Nguyen				19a. Informant's Name/Relationship (Type, Print) Tran N. Tran/ Daughter			
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Windson Way, Camp Hill, PA 17011				20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Cedar Hill Cemetery		20c. Location - City or Town, State 10/5/00 Suitland, MD	
21. Signature of Funeral Service Licensee Andrew J. Cole				22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Silver Spring, MD 20901				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Pneumonia, left lower lobe Due to (or as a consequence of): b. cellulitis, Right foot, after 5 <sup>th</sup> toe amputation Due to (or as a consequence of): c. Diabetes, type II Due to (or as a consequence of): d. Hypertension			
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
28a. Date of Injury (Month, Day Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier Dr. H. H. H.				29c. License number D23429				29d. Date signed (Month, Day, Year) 10/2/2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TON THAI CHIEU, MD 7505 New Hampshire Ave # 310, Langley Park, MD 20783				31. Date filed (Month, Day, Year) OCT 03 2000				32. Registrar's Signature B. Sparks			

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32883

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Elizabeth Taylor

2. Date of Death

Month Day Year  
October 4, 2000

3. Time of Death

10:25 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

4908 Bayard Blvd.

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

579-12-9673

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 30, 1910

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

4908 Bayard Blvd

10f. Zip Code

20816

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

United States Government

17. Father's Name (First, Middle, Last)

John A. Mikesell

18. Mother's Name (First, Middle, Maiden Surname)

Edith E. Spessard

19a. Informant's Name/Relationship (Type, Print)

Robert L. Taylor, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4908 Bayard Blvd., Bethesda, Maryland 20816

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Green Hill Cemetery

Date

20c. Location - City or Town, State

Waynesboro,  
Pennsylvania

21. Signature of Funeral Service Licensee

M00846

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Lung Cancer

Months

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Emphysema

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D42051

29d. Date signed (Month, Day, Year)

October 5, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. Scott Cohen, M.D., 5454 Wisconsin Avenue #1125, Chevy Chase, Maryland 20815-4619

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 17 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32884

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Bernard J. Venverloh, III</i>				2. Date of Death Month Day Year <i>September 29, 2000</i>		3. Time of Death <i>1:55AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>Casey House</i>				4b. City, Town, or Location of Death <i>Rockville</i>		4c. County of Death <i>Montgomery</i>	
Funeral Director	5. Social Security Number <i>226-08-7436</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>39</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>November 7, 1960</i>		9. Birthplace (State or Foreign Country) <i>Missouri</i>
	Usual Residence of Decedent							
10a. State <i>Maryland</i>		10b. County <i>Montgomery</i>		10c. City, Town or Location <i>Germantown</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <i>19710 Crystal Rock Drive #23</i>				10f. Zip Code <i>20874</i>		10g. Citizen of What Country? <i>United States</i>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Caucasian</i>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Civil Environmental Engineer</i>			16b. Kind of Business/Industry <i>Project, Time &amp; Cost</i>	
17. Father's Name (First, Middle, Last) <i>Bernard J. Venverloh, Jr.</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Joan Hoffmeister</i>				
19a. Informant's Name/Relationship (Type, Print) <i>Denise Frise Sister</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>11708 Olde English Drive, Reston, Virginia 20190 #C</i>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Columbia Gardens Cemetery</i>		20c. Location - City or Town, State <i>10/3/2000 Arlington, VA</i>		
21. Signature of Funeral Service Licensee <i>[Signature]</i> CFS				22. Name and Address of Facility <i>Robert J. Murphy Funeral Home, Inc. 4510 Wilson Blvd. Arl. Va. 22203</i>				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <i>Metastatic Carcinoma</i> Due to (or as a consequence of):  b. <i>Colon Cancer</i> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death  <i>6 months</i>  <i>18 Months</i>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Hospice</i>				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>E. P. Libre MD</i>		29c. License number <i>D09470</i>		
				29d. Date signed (Month, Day, Year) <i>SEPTEMBER 29, 2000</i>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Eugene P. Libre, MD 10400 Connecticut Avenue, Kensington, Md. 20895</i>								
31. Date filed (Month, Day, Year) <i>OCT 02 2000</i>				32. Registrar's Signature <i>[Signature]</i>				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32885

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Holland Vainqueur		2. Date of Death Month Day Year September 28, 2000		3. Time of Death 12:41 AM	
	4a. Facility Name (If not institution, give street and number) Holy Cross Hospital		4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 579-90-8701	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) July 23, 1931
	9. Birthplace (State or Foreign Country) Haiti					
To Be Completed by Funeral Director	Usual Residence of Decedent					
	10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring	
	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	10e. Street and Number 1319 Gresham Road		10f. Zip Code 20904		10g. Citizen of What Country? Haiti	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: Black					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) None College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maintenance Engineer		16b. Kind of Business/Industry Voice of America	
	17. Father's Name (First, Middle, Last) Tigon Vainqueur		18. Mother's Name (First, Middle, Maiden Surname) Elizabeth (Unobtainable)			
	19a. Informant's Name/Relationship (Type, Print) Jacques Vainqueur / Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1319 Gresham Road, Silver Spring, Maryland 20904			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		20c. Location - City or Town, State Silver Spring, MD	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904				
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of):					Days
	b. Cerebrovascular Accident Due to (or as a consequence of):					Days
	c. Due to (or as a consequence of):					
To Be Completed by Physician/Medical Examiner	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension					23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined					28. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred					28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier 		29c. License number D32332		29d. Date signed (Month, Day, Year) September 28, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.K. Gupta, M.D. 9801 Georgia Avenue, #220, Silver Spring, Maryland 20902						
31. Date filed (Month, Day, Year) OCT 04 2000		32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 32886

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>MARIA VARGAS</b>		2. Date of Death Month Day Year <b>September 29, 2000</b>		3. Time of Death <b>12:26 P.M.</b>
4a. Facility Name (If not institution, give street and number) <b>Peninsula Regional Medical Center</b>		4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>
5. Social Security Number <b>UNK.</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>25</b> Yrs.	If Under 1 Year Months Days <b>12-17-74</b>	8. Date of Birth (Month, Day, Year) <b>12-17-74</b>
9. Birthplace (State or Foreign Country) <b>MEXICO</b>		10. Usual Residence of Decedent		
10a. State <b>MD</b>	10b. County <b>WICOMICO</b>	10c. City, Town or Location <b>SALISBURY</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>605 GOLDSBOROUGH ST.</b>		10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>MEXICO</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>MEXICAN</b>
14. Race - American Indian, Black, White, etc. Specify: <b>MEXICAN</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEKEEPER</b>		16b. Kind of Business/Industry <b>COMFORT INN</b>		
17. Father's Name (First, Middle, Last) <b>JESUS VARGAS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>SABINA GARCIA VARGAS</b>		
19a. Informant's Name/Relationship (Type, Print) <b>JORGE VARGAS BROTHER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2494-DREW VALLEY RD. N.E. ATLANTA, GEORGIA</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>EL PANTEON DE JEJALPA 104400 JIUTEPEC, MORELOS-MEX.</b>		20c. Location - City or Town, State
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>BENNIE SMITH FPH</b> <b>917 W. ISABELLA ST. SALISBURY, MD. 21801</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Intracerebral Hemorrhage</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <input type="checkbox"/> No
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>September 30, 2000</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>				
31. Date filed (Month, Day, Year) <b>OCT 04 2000</b>		32. Registrar's Signature 		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32887

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bertha Cordelia Wright

2. Date of Death

Month Day Year  
September 30, 2000

3. Time of Death

2:00 PM

4a. Facility Name (If not institution, give street and number)

8015 Maple Ave.

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-28-3549

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 16, 1916

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

7051 Carroll Ave. #405

10f. Zip Code

20912

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Film Assembly Stripper

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Claude Davis

18. Mother's Name (First, Middle, Maiden Surname)

Rachel Tweedy

19a. Informant's Name/Relationship (Type, Print)

Deborah Levy /Social Worker

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

212 Thistle Ct., Silver Spring, MD 20901

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ft Lincoln Cemetery

Date

Oct 11  
2000

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

Beverly R. Helt

22. Name and Address of Facility

Rapp Funeral & Cremation Services  
933 Gist Avenue Silver Spring, MD23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Swallowing Dysfunction

Approximate  
Interval Between  
Onset and Death

1 year

a. Due to (or as a consequence of):

Dementia

years

b. Due to (or as a consequence of):

Parkinson's Disease

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hepatitis A

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Group Home

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Stuart J. Turkewitz M.D.

29c. License number

D31001

29d. Date signed (Month, Day, Year)

10/2/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stuart J. Turkewitz M.D. 7500 Greenway Center Dr. #430, Greenbelt, MD 20770

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 05 2000

32. Registrar's Signature

B. Spade

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32888

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Darlene C. Worsham</b>				2. Date of Death Month Day Year <b>Oct. 4, 2000</b>		3. Time of Death <b>3:50A.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>579-76-0278</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>41 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>Sept. 16, 1959</b>	
	9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Beltsville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>11310 Cherry Hill Road</b>		10f. Zip Code <b>20705</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business/Industry <b>U.S. Government</b>			
	17. Father's Name (First, Middle, Last) <b>Christopher Ray Payne</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Maxine Willie</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Kenneth T. Worsham (husband)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery</b>		Date <b>10/7/2000</b>		20c. Location - City or Town, State <b>Brentwood, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>Donald V. Borgwardt</b>		22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Anterior Myocardial Infarction</b> Due to (or as a consequence of): b. <b>Coronary Artery Disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Approximate Interval Between Onset and Death  a. <b>2 days</b> b. <b>6 years</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Complete heart block</b>  <b>Non insulin dependent Diabetes Mellitis</b>  <b>Hypertension</b>							
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>B. J. Regan</b>		29c. License number <b>D0045121</b>		29d. Date signed (Month, Day, Year) <b>October 4, 2000</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Brian Regan, M.D. Kaiser Permanente 1500 Forest Glen Ave. Silver Spring, Md. 20901</b>							
	31. Date filed (Month, Day, Year) <b>OCT 05 2000</b>		32. Registrar's Signature <b>B. Sparks</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32889

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Nathan Weiss

2. Date of Death Month Day Year September 29, 2000

3. Time of Death 11:45pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number) Holy Cross Hospital

4b. City, Town, or Location of Death Silver Spring

4c. County of Death Montgomery

5. Social Security Number 085-10-7949

6. Sex ☒ M ☐ F

7. Age (In yrs. last birthday) 81 Yrs.

8. Date of Birth (Month, Day, Year) March 15, 1919

9. Birthplace (State or Foreign Country) New York

Usual Residence of Decedent

10a. State Maryland

10b. County Montgomery

10c. City, Town or Location Wheaton

10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 10859 Bucknell Drive

10f. Zip Code 20902

10g. Citizen of What Country? United States

11. Marital Status ☐ Never Married ☒ Married ☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? ☒ Yes ☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant

16b. Kind of Business/Industry Small Business Administration

17. Father's Name (First, Middle, Last) Jacob Weiss

18. Mother's Name (First, Middle, Maiden Surname) Sarah Rothman

19a. Informant's Name/Relationship (Type, Print) Hilda Weiss / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10859 Bucknell Drive, Wheaton, MD 20902

20a. Method of Disposition ☒ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Judean Memorial Gardens

20c. Location - City or Town, State 10/02/00 Olney, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Danzansky Goldberg Memorial Chapels, Inc 1170 Rockville Pike, Rockville, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) Respiratory arrest

a. Due to (or as a consequence of): Pneumonia

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure

23b. Did tobacco use contribute to the cause of death? ☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed? ☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☐ Yes ☒ No

26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? ☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number D52261

29d. Date signed (Month, Day, Year) September 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type/Print) Alan Segal, MD 1517 Hugo Circle, Silver Spring, MD 20906

31. Date filed (Month, Day, Year) OCT 06 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32890

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LAWRENCE E. WATKINS

2. Date of Death

SEPT. 30, 2000

3. Time of Death

10:30 AM

4a. Facility Name (If not institution, give street and number)

Oasys Eldercare

4b. City, Town, or Location of Death

Columbia

4c. County of Death

HOWARD

Funeral  
Director

5. Social Security Number

214-18-1681

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 12, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Jessup

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

9950 Guilford Road, #106

10f. Zip Code

20794

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 45-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Lawrence Watkins

18. Mother's Name (First, Middle, Maiden Surname)

Annie S. Holland

19a. Informant's Name/Relationship (Type, Print)

John Myers, Jr. (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7466 Oakland Mills Rd., Columbia, MD 21046

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Vet. Cem.

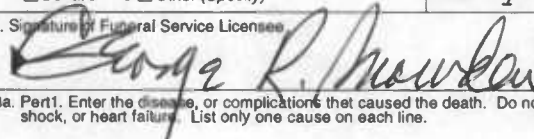
Date

10/6/00

20c. Location - City or Town, State

Crownsville, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

SNOWDEN FUNERAL HOME, P.A.  
ROCKVILLE, MD 20850Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC COLO-RECTAL CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

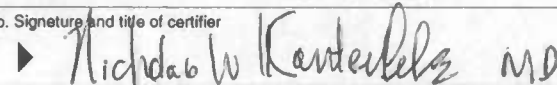
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 MD

29c. License number

D38509

29d. Date signed (Month, Day, Year)

October 3, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NICHOLAS A. KOUTRELAKOS, MD 11065 Little Patuxent Pky Columbia, MD 21044

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 04 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

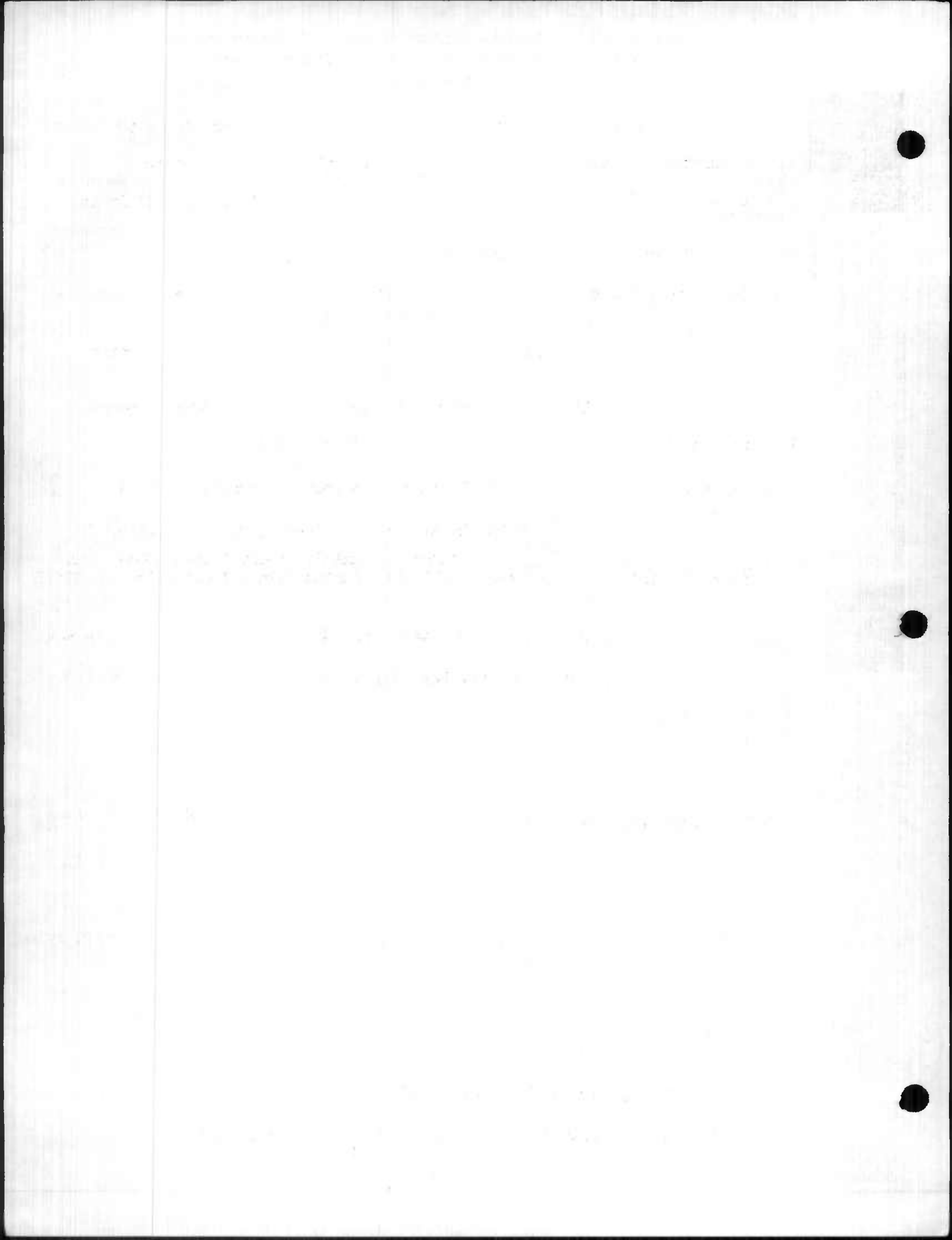
State of Maryland / Department of Health and Mental Hygiene

00 32891

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Wallace R. Winkler</b>				2. Date of Death Month <b>October</b> Day <b>10</b> Year <b>2000</b>		3. Time of Death <b>7:00am</b>	
	4a. Facility Name (If not institution, give street and number) <b>10433 Waterfowl Terrace</b>				4b. City, Town, or Location of Death <b>Columbia</b>		4c. County of Death <b>Howard</b>	
Funeral Director	5. Social Security Number <b>577 40 5335</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b>		8. Date of Birth (Month, Day, Year) <b>Sept 3, 1917</b>	
	9. Birthplace (State or Foreign Country) <b>Illinois</b>		10a. State <b>MD</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Columbia</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>5020 Lake Circle Court</b>		10f. Zip Code <b>21044</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1943-46</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Research Analyst</b>		16b. Kind of Business/Industry <b>Federal Government</b>		17. Father's Name (First, Middle, Last) <b>Alpherd Winkler</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Elsie Stelle</b>		19e. Informant's Name/Relationship (Type, Print) <b>Cleo Winkler/Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5020 Lake Circle Court Columbia, MD 21044</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. Date <b>10-11-2000</b>		20d. Location - City or Town, State <b>Catonsville, MD</b>		21. Signature of Funeral Service Licensee <b>Shawn A. Collins - atty</b>	
	22. Name and Address of Facility <b>Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CARDIAC ARRHYTHMIA</b>		23b. Approximate Interval Between Onset and Death <b>MINUTES</b>		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	23d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ALZHEIMER'S DISEASE</b>		24a. Were an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	26. Piece of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>asst. living</b>		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
State Registrar	28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>W. Andrew Marks MD</b>		29c. License number <b>D31205</b>		29d. Date signed (Month, Day, Year) <b>October 10, 2000</b>	
Division of Vital Records, P.O. Box 68760,	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>W.A. MARKS 2 KNOLL NORTH DRIVE COLUMBIA MD 21045</b>		31. Date filed (Month, Day, Year) <b>OCT 10 2000</b>		32. Registrar's Signature <b>B. Sparks</b>		33. Date of Death (Month, Day, Year) <b>October 10, 2000</b>	
	34. Date of Death (Month, Day, Year) <b>October 10, 2000</b>		35. Date of Death (Month, Day, Year) <b>October 10, 2000</b>		36. Date of Death (Month, Day, Year) <b>October 10, 2000</b>		37. Date of Death (Month, Day, Year) <b>October 10, 2000</b>	





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State of Maryland / Department of Health and Mental Hygiene

Amended Item#28a,b,f perPHYG787 9/21/2000 EW

Certificate of Death

Reg. No.

00 32892

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NATHANIEL Asbury Whittington Sr.

2. Date of Death

July 31 2000

3. Time of Death

1224

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

212-14-4349

6. Sex

15 M 2 F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

11-15-10

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

501 Robinson ST.

10f. Zip Code

21801

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ATTENDANT

16b. Kind of Business/Industry

DEER'S HEAD HOSP.

17. Father's Name (First, Middle, Last)

ARZAH Whittington

18. Mother's Name (First, Middle, Maiden Surname)

HELEN Whittington

19a. Informant's Name/Relationship (Type, Print)

DORIS DOMAHUE - DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

703 College Lane Salisbury, MD 21804

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Family Cemetery

Date

8-4-00

20c. Location - City or Town, State

Kingston, MD

21. Signature of Funeral Service Licensee

Anthony E. Ward

22. Name and Address of Facility

Anthony E. Ward Funeral Home  
30639 Hampden Ave, Princess Anne, MD 21853

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Subdural Hematoma

Due to (or as a consequence of):

b. Rt. Hip Fracture

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day, Year)

7/24/2000

28b. Time of Injury

UNK

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

Falls at home

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

501 Robinson ST, Salisbury, MD

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD DME

29c. License number

D0054127

29d. Date signed (Month, Day, Year)

7/31/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan Davis MD DME 3 Bishop Blvd Delmar MD 21875

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 07 2000

32. Registrar's Signature

Benjamin B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

28A, B, C

State Registrar

ANTHONY J. ...

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32893

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Susie Adams</b>		2. Date of Death Month <b>10</b> Day <b>10</b> Year <b>2000</b>		3. Time of Death <b>8:00 pm</b>														
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death														
Funeral Director	5. Social Security Number <b>218-26-9415</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Mar 19, 1920</b>	9. Birthplace (State or Foreign Country) <b>unk</b>														
	Usual Residence of Decedent																		
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
	10e. Street and Number <b>1217 W. Fayette Street</b>		10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>USA</b>														
	11. Marital Status <b>unk</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:														
	14. Race - American Indian, Black, White, etc. Specify: <b>black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unk</b> College (1-4 or 5+) <b>unk</b>																
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unk</b>		16b. Kind of Business/Industry <b>unk</b>																
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>unk</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>unk</b>																
	19a. Informant's Name/Relationship (Type, Print) <b>University of MD Hospital</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>22 S. Greene Street Baltimore, MD 21201</b>																
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State														
	21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>		22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>																
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <b>Sepsis</b> Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. <b>Pneumonia</b> Due to (or as a consequence of):</td> </tr> <tr> <td>c.  Due to (or as a consequence of):</td> </tr> <tr> <td>d.  Due to (or as a consequence of):</td> </tr> </table>					Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Sepsis</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b. <b>Pneumonia</b> Due to (or as a consequence of):	c. Due to (or as a consequence of):	d. Due to (or as a consequence of):									
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Sepsis</b> Due to (or as a consequence of):	Approximate Interval Between Onset and Death																	
	b. <b>Pneumonia</b> Due to (or as a consequence of):																		
	c. Due to (or as a consequence of):																		
	d. Due to (or as a consequence of):																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																			
<table border="0"> <tr> <td>23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown</td> </tr> <tr> <td>24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> <tr> <td>24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> </tr> </table>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																			
<table border="0"> <tr> <td>25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td colspan="4">26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td>27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined</td> <td>28a. Date of Injury (Month, Day, Year)</td> <td>28b. Time of Injury M</td> <td>28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</td> <td>28d. Describe how injury occurred</td> </tr> <tr> <td colspan="3">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="2">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>					25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred															
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)																
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																			
29b. Signature and title of certifier <b>D. Espy-Smith MD</b>		29c. License number <b>P13374</b>		29d. Date signed (Month, Day, Year) <b>10/10/2000</b>															
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>A. Espy-Smith MD 22 S. Greene St. Baltimore, MD 21201</b>																			
State Registrar	31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature <b>[Signature]</b>																

ORIGINAL



Andrew Augstinak

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State of Maryland / Department of Health and Mental Hygiene 00 32894

amend item 23a,27 per me G789 11/27/00 yf

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Andrew Scott Augustyniak</b>				2. Date of Death Month Day Year <b>October 16, 2000</b>		3. Time of Death <b>2151 pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>216-78-7424</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>30</b> Yrs.		6. Date of Birth (Month, Day, Year) <b>1-7-1970</b>		
	9. Birthplace (State or Foreign Country) <b>Baltimore, Maryland</b>		10a. State <b>MD</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2006 Bank Street</b>		10f. Zip Code <b>21231</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Carpenter</b>		16b. Kind of Business/Industry <b>Paul Rogerson Constr.</b>					
17. Father's Name (First, Middle, Last) <b>Albert Augustyniak</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Irene Colon</b>					
19a. Informant's Name/Relationship (Type, Print) Mother <b>Irene Houston</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3505 E. Lombard St., Baltimore, Maryland 21224</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount</b>		20c. Date <b>10/20/2000</b>		20d. Location - City or Town, State <b>Baltimore, Maryland</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Joseph N. Zannino Jr., Funeral Home 263 South Conkling Street, Baltimore, Maryland 21224</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. HYPERTROPHIC CARDIOMYOPATHY</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier 				29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>October 17, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. LAFON</b> <b>111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32895

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Rose Bunjon</b>				2. Date of Death Month Day Year <b>October 15, 2000</b>		3. Time of Death <b>6 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Genesis- Hamilton</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-16-9323</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 29, 1918</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>4289 Falls Road</b>				10f. Zip Code <b>21211</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Book Binder</b>			16b. Kind of Business/Industry <b>Book Manufacturer</b>	
17. Father's Name (First, Middle, Last) <b>Joseph Bunjon</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Bertha Larosa</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Frank Bunjon (Brother)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4289 Falls Road, Baltimore, Maryland 21211</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial</b>			20c. Location - City or Town, State <b>10/17/00 Cockeysville, Md</b>		
21. Signature of Funeral Service Licensee <b>Burpee-Henss-Seitz Funeral Home, Inc. 21211</b>				22. Name and Address of Facility <b>3631 Falls Road, Baltimore, Maryland</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Ovarian Cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>6 months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of Certifier <b>[Signature]</b>				29c. License number <b>D45475</b>		29d. Date signed (Month, Day, Year) <b>10/17/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Mohammad Rahnama Franklin Square Hospital Balto. MD</b>								
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>				32. Registrar's Signature <b>[Signature]</b>				

Baltimore, Maryland 21215-0020

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32896

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Michael Booker</b>				2. Date of Death Month Day Year <b>Oct. 15, 2000</b>		3. Time of Death <b>8:00pm</b>	
	4a. Facility Name (If not Institution, give street and number) <b>4 Barnacle Court</b>				4b. City, Town, or Location of Death <b>Essex</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>259-98-8010</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>41</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>01-02-58</b>	
	9. Birthplace (State or Foreign Country) <b>GA</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>4 Barnacle Court</b>		10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance</b>		16b. Kind of Business/Industry <b>Hechinger Company</b>			
	17. Father's Name (First, Middle, Last) <b>Alfonza Booker</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Johnnie M. Merriweather</b>		19a. Informant's Name/Relationship (Type, Print) <b>Inell Booker</b>			
To Be Completed by Physician/Medical Examiner	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2848 Oakford Avenue Baltimore, Maryland 21215</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Voshell Mem. Gardens</b>		20c. Location - City or Town, State <b>10-20-2000 Dundalk, MD</b>	
	21. Signature of Funeral Service Licensee <b>Wladimir Wane</b>		22. Name and Address of Facility <b>Baltimore, Maryland 21215</b> <b>WM.C. March FH 4300 Wabash Avenue</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Cardio Respiratory Failure</b> Due to (or as a consequence of): <b>Congestive Heart Failure</b> Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____						Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Aids (Under treatment for Aids 3 1/2 yrs)</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. Signature and title of certifier <b>Charles F. O'Donnell MD</b>	
	29c. License number <b>09383</b>		29d. Date signed (Month, Day, Year) <b>October 17, 2000</b>					
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Charles O'Donnell Harbor House Highrise Village of Cross Keys</b>						31. Date filed (Month, Day, Year) <b>Oct 18 2000</b>	
	32. Registrar's Signature <b>James A. Spats</b>						33. Date of filing (Month, Day, Year) <b>Oct 18 2000</b>	

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 32897

Amended Item#24a,25,26,27,29a perPHYG788 101/8/2000 EW Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KATHRYN F. BOTELER</b>				2. Date of Death Month Day Year <b>AUGUST 27, 2000</b>				3. Time of Death <b>8:30 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>41960 White Point Beach Road</b>				4b. City, Town, or Location of Death <b>Leonardtown</b>				4c. County of Death <b>St. Marys</b>	
Funeral Director	5. Social Security Number <b>214-03-0535</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>Dec 31, 1910</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>St. Marys</b>		10c. City, Town or Location <b>Leonardtown</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	10e. Street and Number <b>41960 White Point Beach Road</b>				10f. Zip Code <b>20650</b>				10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>housewife</b>				16b. Kind of Business/Industry <b>none</b>	
	17. Father's Name (First, Middle, Last) <b>Milton M. Clark</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Daisey O. Brown</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Joyce Tucker/daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>41960 White Point Beach Rd Leonardtown, MD 20650</b>					
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee <b>Joseph B. Van Sant</b>				22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  a. <b>Congestive Heart failure</b> 1994 Due to (or as a consequence of): b. <b>Coronary Art disease</b> 1994 Due to (or as a consequence of): c. <b>Chr obst Pulm disease</b> 1998 Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>033470</b>		29d. Date signed (Month, Day, Year) <b>9/11/00</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. B. Thaver, 24035 Yone Road Rd, Hollywood, MD 20636</b>				31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>				32. Registrar's Signature <b>[Signature]</b>		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32898

AMENDED Item#17 per FH, Item#23a per PhyG788 10/18/2000 EW Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>ALBERTA BALLANGER</i>		2. Date of Death Month Day Year <i>OCTOBER 5, 2000</i>		3. Time of Death <i>8:30AM</i>											
	4a. Facility Name (If not institution, give street and number) <i>Mercy Hospice</i>		4b. City, Town, or Location of Death <i>BALTO.</i>		4c. County of Death <i>N/A</i>											
Funeral Director	5. Social Security Number <i>243-03-2500</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>80</i>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.											
	8. Date of Birth Month Day Year <i>Feb-25-1920</i>		9. Birthplace (State or Foreign Country) <i>N.C.</i>													
Usual Residence of Decedent																
10a. State <i>md</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>BALTO.</i>												
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																
10e. Street and Number <i>500 Allendale St.</i>			10f. Zip Code <i>21229</i>		10g. Citizen of What Country? <i>U.S.A.</i>											
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:												
14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>																
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5th grade</i> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Domestic Worker</i>		16b. Kind of Business/Industry <i>Cleaning Homes</i>												
17. Father's Name (First, Middle, Last) <i>William Bonarion Bonner</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Polly Anna</i>													
19a. Informant's Name/Relationship (Type, Print) <i>ALBERTA Windley</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>500 Allendale St. BALTO. MD. 21229</i>													
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>GARRISON FOREST VA. 10-13-20 Owing's Mills md</i>		20c. Location - City or Town, State												
21. Signature of Funeral Service Licensee <i>Patricia Beth</i>		22. Name and Address of Facility <i>Beth's Funeral Home 1129 N. CAROLINE ST. BALTO. MD. 21213</i>														
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><i>Dehydration</i></td> <td rowspan="4">           Due to (or as a consequence of):            Due to (or as a consequence of):            Due to (or as a consequence of):            Due to (or as a consequence of):         </td> <td rowspan="4">           Approximate Interval Between Onset and Death         </td> </tr> <tr> <td>b.</td> <td><i>Aspiration PNEUMONIA TER MINAL</i></td> </tr> <tr> <td>c.</td> <td><i>Poor gag reflex</i></td> </tr> <tr> <td>d.</td> <td><i>Acute CVA to death</i></td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<i>Dehydration</i>	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death	b.	<i>Aspiration PNEUMONIA TER MINAL</i>	c.	<i>Poor gag reflex</i>	d.	<i>Acute CVA to death</i>
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<i>Dehydration</i>	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death												
	b.	<i>Aspiration PNEUMONIA TER MINAL</i>														
	c.	<i>Poor gag reflex</i>														
	d.	<i>Acute CVA to death</i>														
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																
<table border="0"> <tr> <td colspan="2"> <i>Disruptive vascular aneurysm,</i>  <i>Aspartism, ASCVD</i> </td> <td colspan="2">23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</td> </tr> <tr> <td colspan="2"></td> <td colspan="2">24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> </tr> </table>						<i>Disruptive vascular aneurysm,</i> <i>Aspartism, ASCVD</i>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
<i>Disruptive vascular aneurysm,</i> <i>Aspartism, ASCVD</i>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Hospice</i>														
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M												
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred												
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)												
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																
29b. Signature and title of certifier <i>Patricia Beth</i>		29c. License number <i>D15F47</i>		29d. Date signed (Month, Day, Year) <i>10/6/00</i>												
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>MARNE J Brown 34 St Paul Place Suite 403 21202</i>																
31. Date filed (Month, Day, Year) <i>OCT 18 2000</i>		32. Registrar's Signature <i>James B Sparks</i>														

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene 00 32899

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Edna T. Bechtold</u>				2. Date of Death Month <u>October</u> Day <u>14</u> Year <u>2000</u>		3. Time of Death <u>1:00 pm</u>	
	4a. Facility Name (If not institution, give street and number) <u>1801 Yokona Road</u>				4b. City, Town, or Location of Death <u>Parkville</u>		4c. County of Death <u>Baltimore</u>	
Funeral Director	5. Social Security Number <u>217-05-9330</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>82</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>December 17, 1917</u>	9. Birthplace (State or Foreign Country) <u>Maryland</u>
	Usual Residence of Decedent							
10a. State <u>Maryland</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Parkville</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <u>1801 Yokona Road</u>				10f. Zip Code <u>21234</u>		10g. Citizen of What Country? <u>U.S.A.</u>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Typist</u>		16b. Kind of Business/Industry <u>Black &amp; Decker</u>		
17. Father's Name (First, Middle, Last) <u>Martin Henry Phipps</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Edna Carolyn Rutledge</u>				
19a. Informant's Name/Relationship (Type, Print) <u>John Bechtold - Husband</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1801 Yokona Road, Parkville MD 21234</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>West Liberty U.M. Ch. Cemo</u>		20c. Location - City or Town, State <u>10/17/00 Whitehall, Maryland</u>				
21. Signature of Funeral Service Licensee <u>Stephanie Allen</u>				22. Name and Address of Facility <u>Gwyns Funeral Chapel 8800 Harford Road, Parkville MD 21234</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>a. Cardiac Arrest</u> Due to (or as a consequence of): <u>b. CHF</u> Due to (or as a consequence of): <u>c.</u> Due to (or as a consequence of): <u>d.</u>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Emphysema</u>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <u>[Signature]</u>				29c. License number <u>D 39297</u>		29d. Date signed (Month, Day, Year) <u>10/16/00</u>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Dr. Michael Ro 2314 Ernst Jappa Road, Baltimore MD 21234</u>								
31. Date filed (Month, Day, Year) <u>OCT 18 2000</u>		32. Registrar's Signature <u>[Signature]</u>						

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32900

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Matthias W. Bott, Jr.</u>			2. Date of Death Month Day Year <u>OCTOBER 15 2000</u>		3. Time of Death <u>11:55 PM</u>														
	4a. Facility Name (If not institution, give street and number) <u>GREATER BALTIMORE MEDICAL CENTER</u>			4b. City, Town, or Location of Death <u>TOWSON</u>		4c. County of Death <u>BALTIMORE</u>														
Funeral Director	5. Social Security Number <u>215-20-9088</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>85</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>Dec 16 1914</u>	9. Birthplace (State or Foreign Country) <u>England</u>													
	Usual Residence of Decedent																			
To Be Completed by Funeral Director	10a. State <u>Md</u>	10b. County <u>Baltimore</u>	10c. City, Town or Location <u>Perry Hall</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
	10e. Street and Number <u>9304 Innsbrook Way</u>			10f. Zip Code <u>21236</u>		10g. Citizen of What Country? <u>USA</u>														
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>5+</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Pastor</u>		16b. Kind of Business/Industry <u>Ministry</u>															
	17. Father's Name (First, Middle, Last) <u>Matthias W. Bott, Sr.</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Lilly Stokes</u>																
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>Elizabeth Bott wife</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>9304 Innsbrook Way Perry Hall, Md 21236</u>																
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Moreland Mem. Park</u>		20c. Location - City or Town, State <u>Parkville, Maryland</u>															
	21. Signature of Funeral Service Licensee <u>Heather Wells</u>		22. Name and Address of Facility <u>Evans Funeral Chapel</u> <u>8800 Harford Rd Baltimore, Md 21234</u>																	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>DISSEMINATED CANDIDIASIS</u></td> <td>Approximate Interval Between Onset and Death <u>1 WEEK</u></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. <u>CANDIDA COLITIS</u></td> <td><u>1 WEEK</u></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>							Immediate Cause (Final disease or condition resulting in death)	a. <u>DISSEMINATED CANDIDIASIS</u>	Approximate Interval Between Onset and Death <u>1 WEEK</u>	Due to (or as a consequence of):		b. <u>CANDIDA COLITIS</u>	<u>1 WEEK</u>	Due to (or as a consequence of):		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.		d.
Immediate Cause (Final disease or condition resulting in death)	a. <u>DISSEMINATED CANDIDIASIS</u>	Approximate Interval Between Onset and Death <u>1 WEEK</u>																		
	Due to (or as a consequence of):																			
	b. <u>CANDIDA COLITIS</u>	<u>1 WEEK</u>																		
	Due to (or as a consequence of):																			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.																			
	d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>CORONARY ARTERY DISEASE, CHRONIC</u> <u>RENAL INSUFFICIENCY, CHRONIC OBSTRUCTIVE</u> <u>PULMONARY DISEASE</u>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown														
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred																
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>DAVID E. KAPLAN, MD</u>		29c. License number <u>D005583</u>		29d. Date signed (Month, Day, Year) <u>October 16, 2000</u>														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>DAVID E. KAPLAN, MD; 6701 N. CHARLES ST, ROOM 3853, BALTIMORE, MD 21204</u>																				
31. Date filed (Month, Day, Year) <u>OCT 18 2000</u>		32. Registrar's Signature <u>Benjamin G. Spawls</u>																		

ORIGINAL







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State of Maryland / Department of Health and Mental Hygiene 00 32901

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>William J. Bayer</u>				2. Date of Death Month <u>Oct</u> Day <u>13</u> Year <u>2000</u>		3. Time of Death <u>6:45AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>HCR Manor Care - Towson</u>				4b. City, Town, or Location of Death <u>Towson</u>		4c. County of Death <u>Baltimore</u>	
Funeral Director	5. Social Security Number <u>212-40-2970</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <u>58</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>OCT-31-1941</u>	
	9. Birthplace (State or Foreign Country) <u>MARYLAND</u>		10a. State <u>MARYLAND</u>		10b. County <u>BALTIMORE</u>		10c. City, Town or Location <u>TOWSON</u>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <u>509 EAST JOPPA ROAD</u>		10f. Zip Code <u>21204</u>		10g. Citizen of What Country? <u>U.S.A.</u>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>WHITE</u>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11 YRS.</u> College (1-4 or 5+) <u></u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>CLERK</u>		16b. Kind of Business/Industry <u>SOCIAL SECURITY</u>			
	17. Father's Name (First, Middle, Last) <u>William J. Bayer</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Evelyn Maskell</u>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>Ross Jackson</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>114202 Dove Creek Way Sparks Maryland 21152</u>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>SACRED HEART OF JESUS 2000! OUNDALK, MARYLAND</u>		20c. Location - City or Town, State <u>21234</u>			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>EVAN CHAPLAIN OF MEMORIALS 8800 HARFORD ROAD PARKVILLE MARYLAND</u>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>a. ACUTE BACTERIAL PNEUMONIA</u>  Due to (or as a consequence of): <u>b. CEREBROVASCULAR ACCIDENT</u>  Due to (or as a consequence of): <u>c.</u>  Due to (or as a consequence of): <u>d.</u>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <u>ESSENTIAL HYPERTENSION</u>							
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year) <u></u>		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>D 30641</u>		29d. Date signed (Month, Day, Year) <u>OCTOBER 13 2000</u>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>DR. Ramesh 201 Back River Neck Rd Suite 109 Essex, Md</u>							
	31. Date filed (Month, Day, Year) <u>OCT 18 2000</u>				32. Registrar's Signature <u>[Signature]</u>			

ORIGINAL



amend item 23a,27 per me G789 11/27/00 yf

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Donald Brown</b>			2. Date of Death Month Day Year <b>OCTOBER 10, 2000</b>		3. Time of Death <b>1638 PM</b>					
	4a. Facility Name (If not institution, give street and number) <b>BON SECOURS HOSPITAL</b>			4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death					
Funeral Director	5. Social Security Number <b>212-58-1561</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>48</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>7-31-52</b>	9. Birthplace (State or Foreign Country) <b>Md.</b>			
	Usual Residence of Decedent										
10a. State <b>Md</b>		10b. County		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
10e. Street and Number <b>1913 N. Longwood St.</b>				10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>U.S.A.</b>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Construction</b>			16b. Kind of Business/Industry <b>Brick Layer</b>				
17. Father's Name (First, Middle, Last) <b>John Brown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lonnie Barnes</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Lynice Brown</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2813 Norfolk Ave. Balt. Md 21215</b>							
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Yoshell Garden 10-17-00 Balt. Md</b>			20c. Location - City or Town, State					
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Westley Chavis Chavis Funeral Home 2007 Eastern Ave. 21223</b>							
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>OCTOBER 11, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201</b>											
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32903

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gladys Eileen Brown				2. Date of Death Month Day Year October 10 2000				3. Time of Death 8:45 pm		
	4a. Facility Name (If not institution, give street and number) 3676 Littlestown Pike				4b. City, Town, or Location of Death Westminster				4c. County of Death Carroll		
Funeral Director	5. Social Security Number 210-07-9257		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 94 Yrs.		8. Date of Birth (Month, Day, Year) July 5, 1906		9. Birthplace (State or Foreign Country) Ohio		
	Usual Residence of Decedent										
10a. State MD		10b. County Carroll		10c. City, Town or Location Westminster				10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10a. Street and Number 3676 Littlestown Pike				10f. Zip Code 21158-2029				10g. Citizen of What Country? USA			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hostess				16b. Kind of Business/Industry Restaurant			
17. Father's Name (First, Middle, Last) Daniel Eugene Lally				18. Mother's Name (First, Middle, Maiden Surname) Mary Goldena Belknap							
19a. Informant's Name/Relationship (Type, Print) Nancy J. Mack (Daughter)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3676 Littlestown Pike, Westminster, MD 21158-2029							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Lakemont Memorial Gardens				20c. Location - City or Town, State Davidsonville, MD			
21. Signature of Funeral Service Licensee K. S. Bone				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. COPD Exacerbation Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 1 yr	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Type II diabetes, Hypertension.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier E. S. Bone				29c. License number D38158				29d. Date signed (Month, Day, Year) 10/11/00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lisa Dimarzio 2003 Medical Parkway #100 Annapolis Md 21401											
31. Date filed (Month, Day, Year) OCT 18 2000				32. Registrar's Signature A. Spaul							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32904

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ABRAMS SAIMAN BERTHA				2. Date of Death Month 10/ Day 8/00 Year		3. Time of Death 9:00 PM		
	4a. Facility Name (If not institution, give street and number) LAYHILL NURSING HOME				4b. City, Town, or Location of Death KESINGTON		4c. County of Death MONTGOMERY COUNTY		
Funeral Director	5. Social Security Number 578-50-4390		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 96 Yrs.		8. Date of Birth (Month, Day, Year) 9/15/04		
	9. Birthplace (State or Foreign Country) RUSSIA		10a. State MD.		10b. County MONTGOMERY		10c. City, Town or Location KESINGTON		
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 3227 BEL.PRE. ROAD		10f. Zip Code 20906		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOUSEWIFE		16b. Kind of Business/Industry					
17. Father's Name (First, Middle, Last) JACOB SAIDMAN				18. Mother's Name (First, Middle, Maiden Surname) PEARL STEIN					
19a. Informant's Name/Relationship (Type, Print) CAROLE KOLKER (DAUGHTER)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5814 LINDEN SQAURET. ROCKVILLE MD. 20852					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GEORGETOWN MEDICAL		Date 10-9-00		20c. Location - City or Town, State WASHINGTON D.C.			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Austin Royster Funeral Home 3821 14th STREET WASHINGTON, D.C. 20011					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. ASPIRATION PNEUMONIA Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 2 WEEKS							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ALZHEIMER'S DEMENTIA						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number D35045		29d. Date signed (Month, Day, Year) OCTOBER 17, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip G. Henjum, MD 3416 Olandwood Court #200 Olney, MD 20832		31. Date filed (Month, Day, Year) OCT 18 2000		32. Registrar's Signature 					

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32905

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>John F Baranowski Jr.</b>						2. Date of Death Month <u>October</u> Day <u>12</u> Year <u>2000</u>		3. Time of Death <u>7:50 p.m.</u>	
4a. Facility Name (If not institution, give street and number) <u>Maryland General Hospital</u>						4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>n/a</u>	
5. Social Security Number <u>217-24-1708</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs., last birthday) <u>71</u> Yrs.	8. Date of Birth (Month, Day, Year) <u>June 19 1929</u>	9. Birthplace (State or Foreign Country) <u>Maryland</u>				
Usual Residence of Decedent									
10a. State <u>MD</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Baltimore</u>				10d. Inside City Limits 1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <u>7494 Rabon Ave.</u>				10f. Zip Code <u>21222</u>		10g. Citizen of What Country? <u>USA</u>			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8th</u> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Toe Motor Operator</u>			16b. Kind of Business/Industry <u>Strohs Inc.</u>		
17. Father's Name (First, Middle, Last) <u>John F Baranowski Sr.</u>					18. Mother's Name (First, Middle, Maiden Surname) <u>Margaret Pozniak</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Mary Baranowski / wife</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7494 Rabon Ave. Baltimore Md. 21222</u>					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metro Crematory Inc.</u>		Date <u>10/16/2000</u>		20c. Location - City or Town, State <u>Baltimore MD</u>			
21. Signature of Funeral Service Licensee <u>R. Terry Connelly</u>				22. Name and Address of Facility <u>Connelly Funeral Home of Essex</u> <u>300 Mace Ave. Baltimore MD 21221</u>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Bacterial Pneumonia</u>								Approximate Interval Between Onset and Death	
Immediate Cause (Final disease or condition resulting in death) e. <u>Bacterial Pneumonia</u> Due to (or as a consequence of):									
Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):									
c. Due to (or as a consequence of):									
d. Due to (or as a consequence of):									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <u>Willie Williams M.D.</u>				29c. License number <u>89382</u>		29d. Date signed (Month, Day, Year) <u>October 12, 2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Willie Williams, MD 60 Maryland General Hospital</u>									
31. Date filed (Month, Day, Year) <u>OCT 18 2000</u>				32. Registrar's Signature <u>Sparks</u>					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32906  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia M. Bertrand

2. Date of Death

Month Day Year  
OCT 13 2000

3. Time of Death

1:15 PM

4a. Facility Name (If not institution, give street and number)

Eastpoint Nursing Home

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

214-42-1983

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 13, 1943

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

122 Bouldin St.

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Edward Noz

18. Mother's Name (First, Middle, Maiden Surname)

Ellen White

19a. Informant's Name/Relationship (Type, Print)

Ellen Palugi Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

209 S. Eaton St. Baltimore, MD 21224

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Cemetery

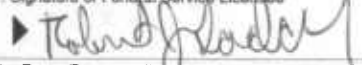
Date

10/18

20c. Location - City or Town, State

Reisterstown, MD

21. Signature of Funeral Service Licensee

▶ 

22. Name and Address of Facility

Moran Ashton Dabrowski Funeral Home, Inc.  
3000 East Baltimore ST Baltimore, MD 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Dementia

Due to (or as a consequence of):

b.

MULT-INFARCT

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

2 YRS

2 YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ 

29c. License number

D45757

29d. Date signed (Month, Day, Year)

October 16, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MATTHEW MCNAMARA 5505 HOPKINS BAYVIEW Circle BAY 21224

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Division of Vital Records, P.O. Box 68760,  
Baltimore, MD 21268  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32907

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN JOSEPH CONNOR, Sr.</b>						2. Date of Death Month Day Year <b>October 15 2000</b>		3. Time of Death <b>6:10am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Stella Maris</b>						4b. City, Town, or Location of Death <b>Timonium</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>218-01-5087</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 27, 1911</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10e. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Towson</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number <b>104 Maryland Avenue</b>				10f. Zip Code <b>21286</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4 or 5+) <b>1 year</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Business Analyst</b>			16b. Kind of Business/Industry <b>Manufacturing</b>			
17. Father's Name (First, Middle, Last) <b>Joseph Patrick Connor</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Anna McNicholas</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Marjorie Connor (wife)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>104 Maryland Avenue Towson, Maryland 21286</b>				
20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial Gardens</b>		20c. Location - City or Town, State <b>10-18-00 Timonium, Maryland</b>				
21. Signature of Funeral Service Licensee <b>George J. Fername</b>						22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Congestive Heart Failure</b>										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
23c. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
23d. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Artery Disease</b>										
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27a. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		27b. Date of Injury (Month, Day Year)		27c. Time of Injury M		27d. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		27e. Describe how injury occurred		
27f. Location (Street and Number or Rural Route Number, City or Town, State)		27g. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		27h. Location (Street and Number or Rural Route Number, City or Town, State)		27i. Location (Street and Number or Rural Route Number, City or Town, State)		27j. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <b>Tariq</b>				29c. License number <b>D43725</b>		29d. Date signed (Month, Day, Year) <b>10/17/00</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Tariq Mahmood, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093</b>										
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature <b>Benita B. Sparks</b>								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32908

Physician  
/Medical  
Examiner1. Decedent's Name (First, Middle, Last)  
LINNIE CHERRY2. Date of Death  
Month 10 Day 10 Year 20003. Time of Death  
2:00PMFuneral  
Director4a. Facility Name (If not Institution, give street and number)  
6001 MUNCASTER MILL ROAD

CASEY HOUSE

4b. City, Town, or Location of Death  
ROCKVILLE4c. County of Death  
MONTGOMERY5. Social Security Number  
244-58-78896. Sex  
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)  
89 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
8/15/119. Birthplace (State or Foreign Country)  
N.C.

Usual Residence of Decedent

10a. State  
MD.10b. County  
MONTGOMERY10c. City, Town, or Location  
GAITHERSBURG10d. Inside City Limits  
1 ☒ Yes 2 ☐ No10e. Street and Number  
18614 SANDPIPER LANE10f. Zip Code  
2087910g. Citizen of What Country?  
U.S.A.11. Marital Status  
1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: BLACK15. Decedent's Education  
(Specify only highest grade completed)  
Elementary/Secondary (0-12) 12th  
College (1-4 or 5+)16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)  
UNKNOWN

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)  
JAMES COWAN18. Mother's Name (First, Middle, Maiden Surname)  
JANIE (UNKNOWN)19a. Informant's Name (Relationship, Title, Print)  
MARTHA WASHINGTON19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
18614 SANDPIPER LANE GAITHERSBURG MD. 2087920a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of cemetery, crematory or other place)  
CEDAR HILL CEMETARY

Date

20c. Location - City or Town, State  
10/14/00 WASHINGTON D.C.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
AUSTIN ROYSTER FUNERAL HOME  
3821 14th St. N.W. WASHINGTON D.C. 20011Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. NON-HODGKIN LYMPHOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)27. Manner of Death  
1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of Injury  
M28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number  
D0947029d. Date signed (Month, Day, Year)  
10/10/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EUGENE P. LIBRE M.D. 10400 CONNECTICUT AVENUE KESINGTON MD. 20895

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32909

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KENNETH C CLARK</b>					2. Date of Death Month Day Year <b>OCT. 14 2000</b>		3. Time of Death <b>1:15 pm</b>		
	4a. Facility Name (If not institution, give street and number) <b>305 Nicholson Road</b>					4b. City, Town, or Location of Death <b>Essex</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>160-20-4156</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 16 1927</b>		9. Birthplace (State or Foreign Country) <b>PA</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>305 Nicholson Road</b>					10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b>Collega</b>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>			16b. Kind of Business/Industry <b>Embassy Dairy</b>		
17. Father's Name (First, Middle, Last) <b>John H Clark</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Ada L Layton</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Garnet Clark / wife</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>305 Nicholson Road Baltimore Md. 21221</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill Cemetery</b>			20c. Location - City or Town, State <b>Baltimore Maryland</b>		20d. Date <b>10/17/2000</b>		
21. Signature of Funeral Service Licensee <b>R. Terry Connelly</b>					22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221</b>					
23a. Part I. Enter the disease, or complications that caused the death. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Head &amp; Neck Cancer relung metastasis</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>2xV5</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.										
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA      Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>David L. Kohn</b>					29c. License number <b>D24532</b>		29d. Date signed (Month, Day, Year) <b>October 17, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DAVID L. KOHN 27 South Greene St. Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>					32. Registrar's Signature <b>Brenda B. Sparks</b>					

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32910

Amended Item 24a, 25, 26 per PHYg788 10/18/2000 EW

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES DUCKETT

2. Date of Death  
Month Day Year  
September 25, 2000

3. Time of Death  
11:26 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

3000 Towanda Ave #110

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

5. Social Security Number

213-34-1099

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug 26, 1937

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State  
MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3000 Towanda Avenue #110

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

driver

16b. Kind of Business/Industry

automobile

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

Margarite Duckett

19a. Informant's Name/Relationship (Type, Print)

Mary L. Duckett/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3300 N. Hilton Street #2 Baltimore, MD 21216

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SUDDEN DEATH

a. Due to (or as a consequence of):

DIABETES

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PERIPHERAL VASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D40059

29d. Date signed (Month, Day, Year)

10/2/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THOMAS DONNELLY UNIV. OF MD MEDICAL CENTER 22 S. GREENE ST BAL MD 21201

31. Data filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32911

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RICHARD EUGENE EVERETT

2. Date of Death

October 16, 2000

3. Time of Death

6:59 P.M.

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

212 18 4062

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept 26, 1916

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HARFORD

10c. City, Town or Location

JARRETTSTOWN

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1406 CHROME HILL ROAD

10f. Zip Code

21084

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: W.W.II

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

7YRS.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CARPENTER

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

JOHN E. EVERETT

18. Mother's Name (First, Middle, Maiden Surname)

MARGARET LEBAN

19a. Informant's Name/Relationship (Type, Print)

SANDRA E. ROBERTS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1228 CHROME HILL ROAD JARRETTSTOWN MARYLAND 21084

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT-ZION CEMETERY

Date

OCT 20, 2000

20c. Location - City or Town, State

BELL AIR MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVANS FUNERAL CHAPEL - BELL AIR, P.A. 21080  
322 WOODBURN DRIVE FOREST HILL, MARYLAND

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chest and Abdominal Injuries  
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☒ Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation  
☒ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

10-16-00

28b. Time of Injury

1749 P.M.

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

motor vehicle collision

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

street

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1227 Chrome Hill Rd Jarrattstown, Md

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] Dennis J. Chute, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

October 17, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dennis J. Chute, MD

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

[Signature] Denise B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item #4a per PHYg788 10/18/2000 EW

## Certificate of Death

Reg. No. 00 32912

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dolores H. Ellerman</b>				2. Date of Death Month Day Year <b>October 10, 2000</b>		3. Time of Death <b>9:30 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Charlestown Retirement Center Apt HR 325</b>				4b. City, Town, or Location of Death <b>Catonsville</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>215-09-8616</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 25, 1920</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>715 Maiden Choice Lane Apt. H.R.325</b>		10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (14-0r 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Home</b>		17. Father's Name (First, Middle, Last) <b>Henry Boss</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Helen Granger</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Leroy Ellerman (Husband)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>715 Maiden Choice Lane Apt. HR325 Catonsville, Md. 21228</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery</b>		20c. Location - City or Town, State <b>10/13/00 Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Kevin E. Ecker</b> <b>McCully-Polyniak Funeral Home, P.A.</b> <b>237 E. Patapsco Avenue Baltimore, Maryland 21225</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic renal cell carcinoma</b> Due to (or as a consequence of): <b>months</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury</b> <b>M</b> <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>00030989</b>		29d. Date signed (Month, Day, Year) <b>October 11 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Myla M Carpenter MD, 714 Maiden Choice Ln Catonsville</b>		31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature 					

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32913

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DOROTHY CAROLYN FASTIE</b>				2. Date of Death Month Day Year <b>October 13, 2000</b>		3. Time of Death <b>7:15 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Blakehurst Retirement Community</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore County</b>	
Funeral Director	5. Social Security Number <b>098-22-6618</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept 17, 1915</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore County</b>		10c. City, Town or Location <b>Towson</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>1055 W. Joppa Road</b>			
	10f. Zip Code <b>21204</b>				10g. Citizen of What Country? <b>USA</b>			
To Be Completed by Physician/Medical Examiner	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4+</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Elementary Teacher</b>		16b. Kind of Business/Industry <b>Music Education</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>William Ferdinand Fastie</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Carolyn Saumenig</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>William H. Fastie (Nephew)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7110 Sheffield Road, Baltimore, Maryland 21212</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		20c. Location - City or Town, State <b>10/21/2000 Baltimore, Maryland</b>		20d. Date	
	21. Signature of Funeral Service Representative <b>Martin D. Lawson (MO0358)</b>		22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212</b>					
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. partial bowel obstruction</b> Due to (or as a consequence of): <b>3 weeks</b> <b>b. metastatic colon cancer</b> Due to (or as a consequence of): <b>6 weeks</b> <b>c.</b> Due to (or as a consequence of): <b>d.</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D32783</b>		29d. Date signed (Month, Day, Year) <b>10/16/00</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Adams, M.D., 6565 North Charles Street, Towson, Maryland 21204</b>							
	31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature <b>[Signature]</b>					



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00-32914

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BABY GIRL FROMMEYER

2. Date of Death

Month

Day

Year

October 7, 2000

3. Time of Death

5:42 AM

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

NONE

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min

8. Date of Birth

(Month, Day, Year)

30 Oct 7, 2000

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1921 Midland Road

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

none

College (1-4 or 5+)

none

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

none

16b. Kind of Business/Industry

none

17. Father's Name (First, Middle, Last)

Ron Frommeyer

18. Mother's Name (First, Middle, Maiden Surname)

Georgia Parry

19a. Informant's Name/Relationship (Type, Print)

Georgia Parry/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1921 Midland Road Baltimore, MD 21222

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street

Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Prematurity

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Subarachnoid Hemorrhage

Due to (or as a consequence of):

c. Respiratory Distress with No Evidence of Aeration of Lungs

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kottapalli

29c. License number

D 22511

29d. Date signed (Month, Day, Year)

10/7/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sita Kottapalli MD, 9000 Franklin Square Drive Baltimore Maryland 21237

State  
Registrar

31. Date filed (Month, Day, Year)

Oct 18 2000

32. Registrar's Signature

James A. Sparks

ORIGINAL

Frommeyer, Babygirl  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32915

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Samuel Fanzone</b>		2. Date of Death Month Day Year <b>October 17, 2000</b>		3. Time of Death <b>4:15 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Bayview</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>218-07-7065</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Mar. 20, 1912</b>		9. Birthplace (State or Foreign Country) <b>Pa.</b>		
Usual Residence of Decedent					
10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Dundalk</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>7133 Martell Ave</b>			10f. Zip Code <b>21222</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11 yrs.</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machinist</b>		16b. Kind of Business/Industry <b>Building Materials</b>	
17. Father's Name (First, Middle, Last) <b>Carmen Fanzone</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Terravecchia</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Ronald Fanzone son</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 Hunt Farms Ct. Sparks, Md. 21152</b>		
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bayview Crematory</b>		20c. Location - City or Town, State <b>Baltimore City</b>	
20d. Date <b>Oct 21 2000</b>					
21. Signature of Funeral Service Licensee <b>Anthony Connelly</b>		22. Name and Address of Facility <b>Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222</b>			
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death) a. <b>Subarachnoid hemorrhage</b> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebrovascular disease, pneumonia</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Amy Knight MD</b>		29c. License number <b>D47533</b>		29d. Date signed (Month, Day, Year) <b>October 17, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Amy Knight MD, 4940 Eastern Ave., Baltimore, 21224</b>					
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature <b>Beverly B Sparks</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOUGLAS ROY FRENCH				2. Date of Death Month Day Year October 14, 2000				3. Time of Death 3:00 P.M.	
	4a. Facility Name (If not institution, give street and number) Peninsula Regional Medical Center				4b. City, Town, or Location of Death Salisbury				4c. County of Death Wicomico	
Funeral Director	5. Social Security Number 363-52-9815		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 51 Yrs.		8. Date of Birth (Month, Day, Year) JULY 7, 1949		9. Birthplace (State or Foreign Country) MICHIGAN	
	Usual Residence of Decedent									
10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location GLEN BURNIE				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number 609 NEW JERSEY AVE., N.E.				10f. Zip Code 21060				10g. Citizen of What Country? UNITED STATES		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: VIET NAM		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) FEDERAL EMPLOYEE				16b. Kind of Business/Industry FOOD AND DRUG ADMINISTRATION		
17. Father's Name (First, Middle, Last) ROY FRENCH				18. Mother's Name (First, Middle, Maiden Surname) VETELINE LEPOUTTRE						
19a. Informant's Name/Relationship (Type, Print) DOLORES FRENCH / WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 NEW JERSEY AVE., N.E., GLEN BURNIE, MD 21060						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) CROWNSVILLE MD VET. CEM.		Data OCT. 20 2000		20c. Location - City or Town, State CROWNSVILLE, MARYLAND				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility KIRLKEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. CARDIAL TAMPONADE Due to (or as a consequence of): b. RUPTURED AORTIC DISSECTION Due to (or as a consequence of): c. HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) October 16, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPLE, MD 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) OCT 18 2000		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32917

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Lester J. Fischer				2. Date of Death Month Day Year October 15 2000		3. Time of Death 9:50 A	
	4a. Facility Name (If not institution, give street and number) Stella Maris at Mercy Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death n/a	
Funeral Director	5. Social Security Number 214-22-2707	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 4/25/1928		9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent							
10a. State MD		10b. County n/a		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10a. Street and Number 155 South Grundy Street Apt. 111				10f. Zip Code 21224		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pallet Maker			16b. Kind of Business/Industry Tirschman Lumber Co.	
17. Father's Name (First, Middle, Last) Frank Fischer				18. Mother's Name (First, Middle, Maiden Surname) Mildred Bievens				
19a. Informant's Name/Relationship (Type, Print) wife Mary Fischer				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 155 S. Grundy St. Apt. 111, Baltimore, MD 21224				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee <i>Joseph N. Zannino Jr.</i>				22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Home 263 South Conkling Street, Baltimore, Maryland 21224				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Metastatic Lung Cancer</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>HOSPICE</i>				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>David Riseberg</i>				29c. License number D40854		29d. Date signed (Month, Day, Year) October 15, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID RISEBERG 301 St Paul Pl BALTIMORE MD 21202								
31. Date filed (Month, Day, Year) OCT 18 2000				32. Registrar's Signature <i>Benita B. Sparks</i>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32918

Amended Item#19b perFHG788 10/18/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Lorraine E. Gaither</b>		2. Date of Death Month <b>October</b> Day <b>14</b> Year <b>2000</b>		3. Time of Death <b>12:20 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Gilchrist Center</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>219-32-9942</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>April 1, 1939</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>740 Poplar Grove St. APT 10H</b>		
	10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>0</b>		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>Charles Gaither</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Harriet</b>		
	19a. Informant's Name/Relationship (Type, Print) (Niece) <b>Mrs. Mattie Clay</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3003 Belmont Ave. Balto. Md. 21216</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		20c. Location - City or Town, State <b>Balto. Md.</b>
	21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>		22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) <b>GASTRIC CANCER</b>					<b>7 mo</b>
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>HOSPICE</b>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Michael [Signature]</b>		29c. License number <b>030433</b>	29d. Date signed (Month, Day, Year) <b>10/14/00</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>CHOMIC 6701 N CHARLES ST BALTIMORE MD 21204</b>					
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature <b>[Signature]</b>			

ORIGINAL







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32919

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EDWIN DAVID GLICKMAN</b>				2. Date of Death Month Day Year <b>OCTOBER 15, 2000</b>		3. Time of Death <b>2:40 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>BRIGHTWOOD MERIDIAN NURSING HOME</b>				4b. City, Town, or Location of Death <b>LUTHERVILLE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>218-28-1649</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT. 11, 1932</b>	
	10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>6728 CHOKEBERRY ROAD</b>				10f. Zip Code <b>21209</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>KOREA</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PROPRIETOR</b>		16b. Kind of Business/Industry <b>FURNITURE COMPANY</b>	
	17. Father's Name (First, Middle, Last) <b>JEROME GLICKMAN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>CECELIA SACKS</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>MARCIA GLICKMAN / WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6728 CHOKEBERRY ROAD - BALTIMORE, MD 21209</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>OHEB SHALOM MEMORIAL PARK</b>		20c. Location - City or Town, State <b>10/17/00 REISTERSTOWN, MD</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. <b>PARKINSONS DISEASE</b>							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier 				29c. License number <b>D20333</b>		29d. Date signed (Month, Day, Year) <b>10/16/00</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>K. M. ZOUIE MD 1838 GARBENTREE RD PIKESVILLE MD 21208</b>							
	31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>				32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32920

AMEND#17 PER F.H. G788 10-18-2000 JAB Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JACOB

GLUSHAKOW

2. Date of Death

October 12 2000

3. Time of Death

9:06 PM

4a. Facility Name (If not institution, give street and number)

Sinai of Baltimore

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-12-4328

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUL.23,1914

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1920 SOUTH ROAD

10f. Zip Code

21209

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ARTIST

16b. Kind of Business/Industry

ART

17. Father's Name (First, Middle, Last)

ABRAHAM

DAVID

Dr

GLUSHAKOW

18. Mother's Name (First, Middle, Maiden Surname)

ESTHER

NOVIKOV

19a. Informant's Name/Relationship (Type, Print)

RIVA NOVEY / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1920 SOUTH ROAD - BALTIMORE, MD 21209

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HILLTOP SERVICE CORP.

Date

10/16/00

20c. Location - City or Town, State

TOWSON, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Hypertension

Adenocarcinoma of the Prostate

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient

☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Helen Z. Norwood, M.D.

29c. License number

Res 000

29d. Date signed (Month, Day, Year)

October 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Helen Z. Norwood, M.D., 2401 West Belvedere Baltimore, MD 21215

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

James S. Sparks



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State of Maryland / Department of Health and Mental Hygiene

00 32921

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Josephine Gilmore				2. Date of Death Month Day Year October 8 2000				3. Time of Death 12:00 pm	
	4e. Facility Name (If not institution, give street and number) Chesapeake Hospice House				4b. City, Town, or Location of Death Linthicum				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 212-30-4816		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) Aug. 9, 1911		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	10e. Street and Number 781 Eastern Point Road				10f. Zip Code 21401		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Bookkeeper			16b. Kind of Business/Industry Retail/Clothing		
	17. Father's Name (First, Middle, Last) Benjamin Galloway				18. Mother's Name (First, Middle, Maiden Surname) Josephine Cadle					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Samuel W. Anderson, Jr. (Son)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 781 Eastern Point Road, Annapolis, MD 21401					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Hillcrest Cemetery		Date 10/11 2000		20c. Location - City or Town, State Annapolis, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401					
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Renal Failure Due to (or as a consequence of): b. Renovascular Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown									
Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Chesapeake Hospice House					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred										
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)										
28f. Location (Street and Number or Rural Route Number, City or Town, State)										
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	29b. Signature and title of certifier 				29c. License number 03155-1		29d. Date signed (Month, Day, Year) October 11, 2000			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Russell A. DeLeon: 1600 S-Crain Highway, Glen Burnie, Md. 21061									
31. Date filed (Month, Day, Year) OCT 18 2000										
32. Registrar's Signature 										

ORIGINAL

— *Handwritten signature* —



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State of Maryland / Department of Health and Mental Hygiene

00 32922

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>VERNON Harris</b>				2. Date of Death Month <b>October</b> Day <b>11<sup>th</sup></b> Year <b>2000</b>		3. Time of Death <b>4:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>BON SECOURS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>213-20-8614</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Apr 29, 1926</b>	
	10a. State <b>MD</b>		10b. County		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <b>1217 W. Fayette Street</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unk</b> College (1-4 or 5+) <b>unk</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unk</b>		16b. Kind of Business/Industry <b>unk</b>	
	17. Father's Name (First, Middle, Last) <b>unk</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>unk</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Bon Secours Hospital</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2000 W. Baltimore Street Baltimore, MD 21223</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>in state</b>				20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State	
	21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dehydration</b>							
	23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Terance Lamb M.D.</b>				29c. License number <b>D37203</b>		29d. Date signed (Month, Day, Year) <b>October 11 2000</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Terance Lamb M.D. Bon Secours Hospital Baltimore MD 21223</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>				32. Registrar's Signature <b>[Signature]</b>			



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State of Maryland / Department of Health and Mental Hygiene

00 32923

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LEONARD TERRANCE HOEN</b>				2. Date of Death Month Day Year <b>OCT. 16, 2000</b>		3. Time of Death <b>7:40AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>GILCHRIST HOSPICE CTR. - G.B.M.C.</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>215-54-4905</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>46</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JULY 13, 1954</b>		9. Birthplace (State or Foreign Country) <b>MD.</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>HARFORD</b>		10c. City, Town or Location <b>JOPPA</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>1011 DONNAWOOD DRIVE</b>				10f. Zip Code <b>21085</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>+4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COMPUTER PROGRAMMER</b>		16b. Kind of Business/Industry <b>QUADRAMED CORP.</b>		
17. Father's Name (First, Middle, Last) <b>LEONARD S. HOEN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>DOROTHY JEAN EUDRIDGE</b>				
19a. Informant's Name/Relationship (Type, Print) <b>TERRIE LYNN COTTRILL HOEN, SPOUSE 1011 DONNAWOOD DR. JOPPA, MD. 21085</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>EVANS FUNERAL CHAPEL</b>		Date <b>OCT. 17, 2000</b>		20c. Location - City or Town, State <b>FOREST HILL, MD</b>		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>EVANS FUNERAL CHAPEL</b> <b>8800 HARFORD RD. PARKVILLE, MD. 21234</b>				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Colo-rectal cancer</b> Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ Approximate Interval Between Onset and Death <b>4 years</b>								
23b. Part 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Colo-rectal cancer</b> Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28c. Describe how injury occurred		
28d. Location (Street and Number or Rural Route Number, City or Town, State)				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>025205</b>		29d. Date signed (Month, Day, Year) <b>October 16, 2000</b>		
30. Name and address of person who completed cause of death (Form 3a) (Type, Print) <b>W.A. Riley 6701 N. Charles St. Balto. md 2120x</b>								
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>				32. Registrar's Signature <i>[Signature]</i>				

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene 00 32924

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Burton G. Hood</i>		2. Date of Death Month <i>Oct.</i> Day <i>16</i> Year <i>2000</i>		3. Time of Death <i>12:50 PM</i>
	4a. Facility Name (If not institution, give street and number) <i>Howard County General Hospital</i>		4b. City, Town, or Location of Death <i>Columbia</i>		4c. County of Death <i>Howard</i>
Funeral Director	5. Social Security Number <i>215-24-8819</i>	6. Sex <i>Male</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>73</i> Yrs.	8. Date of Birth (Month, Day, Year) <i>Aug. 17, 1927</i>	
	9. Birthplace (State or Foreign Country) <i>Maryland</i>				
Usual Residence of Decedent					
10a. State <i>MD</i>		10b. County <i>Anne Arundel</i>		10c. City, Town or Location <i>Odenton</i>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <i>1247 Breitwert Avenue</i>		10f. Zip Code <i>21113</i>		10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>WWII</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>White</i>					
15. Decedent's Education (Specify only highest grade completed) <i>Elementary/Secondary (0-12) 10</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>HVAC Engineer</i>		16b. Kind of Business/Industry <i>Air &amp; Refrigeration</i>	
17. Father's Name (First, Middle, Last) <i>Burton Hood</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Frances Gottlieb</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Peggy Hood (Wife)</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1247 Breitwert Avenue, Odenton, MD 21113</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Glen Haven Cemetery</i>		20c. Location - City or Town, State <i>Glen Burnie, MD</i>	
21. Signature of Funeral Service Licensee <i>James</i>		22. Name and Address of Facility <i>Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Nosocomial Pneumonia</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. Due to (or as a consequence of):</i> <i>c. Due to (or as a consequence of):</i> <i>d. Due to (or as a consequence of):</i>		Approximate Interval Between Onset and Death <i>10 days</i>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Renal Failure, Pleural Effusions, Decompenated Congestive Heart Failure, Peripheral Vascular Disease, Arteriochronic Obstructive Pulmonary Disease, Sepsis</i>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year) <i>M</i>		28b. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28c. Describe how injury occurred		28d. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>James</i>		29c. License number <i>D46120</i>	
29d. Date signed (Month, Day, Year) <i>Oct. 16, 2000</i>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>F DeLeon 10724 Little Potomac Pkwy, Columbia, MD 21044</i>					
31. Date filed (Month, Day, Year) <i>OCT 18 2000</i>		32. Registrar's Signature <i>James</i>			

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 32925

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Patricia M. Harvey</b>				2. Date of Death Month <b>Oct.</b> Day <b>16,</b> Year <b>2000</b>				3. Time of Death <b>1:50P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>85 Will-O-Brook Dr.</b>				4b. City, Town, or Location of Death <b>Pasadena</b>				4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>216-40-2440</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b> Yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Year) <b>3-3-1938</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Pasadena</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Usual Residence of Decedent		10e. Street and Number <b>85 Will-O-Brook Dr.</b>				10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b>		College (1-4 or 5+) <b>0</b>		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>				16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>Alvin W. Robertson</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Conrad</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Jerome E. Harvey (Husband)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>85 Will-O-Brook Dr. Pasadena, MD. 21122</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Mem. Park</b>				20c. Location - City or Town, State <b>10-19-00 Glen Burnie, MD.</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>McCully-Polyniak Funeral Home P.A.</b> <b>3204 Mountain Rd. Pasadena, MD. 21122</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Lung cancer</b>		Due to (or as a consequence of):						Approximate Interval Between Onset and Death <b>1 year</b>		
Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):								
Due to (or as a consequence of):										
Due to (or as a consequence of):										
Due to (or as a consequence of):										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown						
				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 				29c. License number <b>D39505</b>		29d. Date signed (Month, Day, Year) <b>October 17, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Yudhish Markan, 1600 Wain Hwy #602, Glen Burnie MD 21061</b>										
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



ADH  
JAMES HEIM  
00-5812-510

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State of Maryland / Department of Health and Mental Hygiene

00 32926

amend item 23a,ptII, 23b., 27 per me G788 10/19/00 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Russell Heim</b>		2. Date of Death Month Day Year <b>OCTOBER 11, 2000</b>		3. Time of Death <b>1657 PM</b>
	4e. Facility Name (If not institution, give street and number) <b>ST. AGNES HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>165-34-0876</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>56</b> Yrs.	If Under 1 Year Months Days If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 22, 1944</b>
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MD</b>	10b. County <b>Baltimore</b>	10c. City, Town or Location <b>Essex</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>150 Wiltshire Road</b>		10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Parts Clerk</b>		16b. Kind of Business/Industry <b>Teltronic Baltimore Inc.</b>
	17. Father's Name (First, Middle, Last) <b>Ralph E. Heim</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Jane Russell</b>		
	19e. Informant's Name/Relationship (Type, Print) <b>Ralph E. Heim/Brother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>213 Patapsco Avenue, Baltimore, MD 21222</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Holly Hill</b>		20c. Location - City or Town, State <b>10/16/00 Baltimore, MD</b>
	21. Signature of Funeral Service Licensee <b>R. Terry Connelly</b>		22. Name and Address of Facility <b>Connelly Funeral Home Of Essex 300 Mace Avenue Baltimore, MD 21221</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>e. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CIRRHOSIS</b>				
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>28b. Time of Injury</b> M <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>28d. Describe how injury occurred</b> <b>28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify)</b> <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>		
State Registrar	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier <b>J. Pustaner M.D.</b>		29c. License number <b>OCME</b>		
	29d. Date signed (Month, Day, Year) <b>OCTOBER 12, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pustaner 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature <b>B. Sparks</b>			

Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32927

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) CHERYL L HOWARD				2. Date of Death Month Day Year OCT. 15 2000		3. Time of Death 10:45pm	
	4a. Facility Name (If not institution, give street and number) 917 Punjab Court				4b. City, Town, or Location of Death Essex		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 214-50-6135		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 52 Yrs.		8. Date of Birth (Month, Day, Year) June 29 1948	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Essex	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 917 Punjab Court		10f. Zip Code 21221	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 15th	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Assistant				16b. Kind of Business/Industry Social Security			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) John J Bayer				18. Mother's Name (First, Middle, Maiden Surname) Maxine Reeves			
	19a. Informant's Name/Relationship (Type, Print) Deborah Howard / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 S. Linwood Ave. Baltimore Maryland 21224			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc. 10/18/2000		20c. Location - City or Town, State Baltimore Md.	
	21. Signature of Funeral Service Licensee R. Terry Connelly				22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ovarian Carcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):				Approximate Interval Between Onset and Death 6 mos.			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Michael McCollum			
To Be Completed by Physician/Medical Examiner	29c. License number D41490				29d. Date signed (Month, Day, Year) 10-17-2000			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael McCollum, MD 9105 Franklin Square Dr. Balt. 21237				31. Date filed (Month, Day, Year) OCT 18 2000			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature Barbara B. Sparks				33. Date of Death (Month, Day, Year) OCT 15 2000			
	34. Date of Death (Month, Day, Year) OCT 15 2000				35. Date of Death (Month, Day, Year) OCT 15 2000			

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32928

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) OTIS JOHNSON				2. Date of Death Month Day Year October 16 2000		3. Time of Death 5:48am	
	4a. Facility Name (If not institution, give street and number) Good Samaritan Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 246-40-5930		6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 06-02-21	9. Birthplace (State or Foreign Country) NC
	Usual Residence of Decedent				10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State MD		10b. County NA		10f. Zip Code 21218		10g. Citizen of What Country? USA		
10e. Street and Number 401 E. 25th Street Apt. 11A				10f. Zip Code 21218		10g. Citizen of What Country? USA		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown NA				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Master Mechanic		16b. Kind of Business/Industry Automotive		
17. Father's Name (First, Middle, Last) Lee Johnson				18. Mother's Name (First, Middle, Maiden Summa) Cora Smith				
19a. Informant's Name/Relationship (Type, Print) Alean Johnson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 401 E. 25th Street Apt. 11A Baltimore, MD				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens		20c. Location - City or Town, State 10-20-2000 Dundalk, MD		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Myocardial Infarct Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage Renal Disease, Sick Sins Syndrome						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number P13453		29d. Date signed (Month, Day, Year) October 17 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GONZALO GIANAZZA, 7601 Loch Raven Boulevard, Baltimore								
31. Date filed (Month, Day, Year) OCT 18 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32929

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Luke F. Johnson				2. Date of Death Month Day Year October 8, 2000		3. Time of Death 4 PM	
	4a. Facility Name (If not institution, give street and number) Mercy Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death	
Funeral Director	5. Social Security Number 217-20-5247		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 75		8. Date of Birth (Month, Day, Year) 9/13/25	
	9. Birthplace (State or Foreign Country) Nelson Co, VA.		10a. State Md.		10b. County Baltimore		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2741 E. Preston Street.		10f. Zip Code 21213		10g. Citizen of What Country? USA	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Steel Worker		16b. Kind of Business/Industry Bethlehem Steel Co.		17. Father's Name (First, Middle, Last) Walter Johnson	
	18. Mother's Name (First, Middle, Maiden Surname) Hallie Johnson		19a. Informant's Name/Relationship (Type, Print) Luke Johnson Jr. Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5912 Highgate Dr. Baltimore, Maryland 21215		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland National Pk		20c. Date 10/14/00		20d. Location - City or Town, State Laurel, Md.		21. Signature of Funeral Service Licensee Lloyd M. Estep	
	22. Name and Address of Facility Estep Brothers Funeral Ser. P.A. 1300 Eutaw Place, Baltimore, Md.		22. Name and Address of Facility Estep Brothers Funeral Ser. P.A. 1300 Eutaw Place, Baltimore, Md.		22. Name and Address of Facility Estep Brothers Funeral Ser. P.A. 1300 Eutaw Place, Baltimore, Md.		22. Name and Address of Facility Estep Brothers Funeral Ser. P.A. 1300 Eutaw Place, Baltimore, Md.	
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CANCER OF PENIS Due to (or as a consequence of): b. CANCER OF PROSTATE Due to (or as a consequence of): c. Due to (or as a consequence of): d.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice				27. Manner of Death <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier David R. Spinks			
	29c. License number D 40854				29d. Date signed (Month, Day, Year) October 9, 2000			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID RISEBERG 301 ST PAUL PI BALTIMORE, MD 21202				31. Date filed (Month, Day, Year) OCT 18 2000			
	32. Registrar's Signature David R. Spinks				33. Date of filing (Month, Day, Year) OCT 18 2000			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: #1  
Amended Item#5,6 perFHG788 10/27/2000 EW

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32930

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rosemarie Zipporah Johnson				2. Date of Death Month Day Year October 11 2000		3. Time of Death 10:30 pm		
	4a. Facility Name (If not institution, give street and number) 2917 A Fernandez Court				4b. City, Town, or Location of Death Ft. Meade		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 671-68-5834	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 37 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 17, 1963		9. Birthplace (State or Foreign Country) Jamaica	
	Usual Residence of Decedent								
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Ft. Meade		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10a. Street and Number 2917 A Fernandez Court				10f. Zip Code 20755		10g. Citizen of What Country? <del>USA</del> JAMAICA			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier		16b. Kind of Business/Industry Retail			
17. Father's Name (First, Middle, Last) Marcus Grant				18. Mother's Name (First, Middle, Maiden Surname) Eva Wilson					
19a. Informant's Name/Relationship (Type, Print) (Husband) Michael Anthony Johnson				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2917 A Fernandez Court, Ft. Meade, MD 20755					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hollywood Community Cem.		Date 10/18 2000		20c. Location - City or Town, State Orange Texas			
21. Signature of Funeral Service Licensee <i>Theresa P. Kutta</i>				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <i>Non Hodgkins Lymphoma</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								Approximate Interval Between Onset and Death <i>16 months</i>	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Theresa P. Kutta MD</i>				29c. License number DL 21981		29d. Date signed (Month, Day, Year) 13 OCT 00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Lloyd H. Ketchum MD Hemonc Soc. Walter Reed Army Med Center Washington</i>									
31. Date filed (Month, Day, Year) OCT 18 2000		32. Registrar's Signature <i>James G. Sparks</i>							
State Registrar									

Baltimore, Maryland 21215-0020

perml. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32931

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLES THOMAS KOCHER, SR.

2. Date of Death

OCTOBER 14, 2000

3. Time of Death

11:45 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

1428 Wabash Dr.

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

HARFORD

5. Social Security Number

188-09-5609

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

NOV. 24, 1917

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Md.

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

1428 Wabash Dr.

10f. Zip Code

21015

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

brakeman

16b. Kind of Business/Industry

Railroad

17. Father's Name (First, Middle, Last)

Charles B. Kocher

18. Mother's Name (First, Middle, Maiden Surname)

Mary Adamson

19a. Informant's Name/Relationship (Type, Print)

Betty V. Kocher wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1428 Wabash Dr. Bel Air Md 21015

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EVANS FUNERAL CHAPEL - BEL AIR, P.A.

Date

OCT. 16, 2000

20c. Location - City or Town, State

FOREST HILL MARYLAND

21. Signature of Funeral Service Licensee

Dean Vassar

22. Name and Address of Facility

EVANS FUNERAL CHAPEL - BEL AIR, P.A.  
302 WILFORD DRIVE FOREST HILL MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ISCHEMIC CARDIOMYOPATHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SICK SINUS SYNDROME

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

Other:

26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Medical Examiner 2 Medical Examiner

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dean Vassar MD.

29c. License number

D0016036

29d. Date signed (Month, Day, Year)

OCTOBER 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. DEAN VASSAR, M.D. 104 PLUM TREE ROAD

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

B. Apant

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

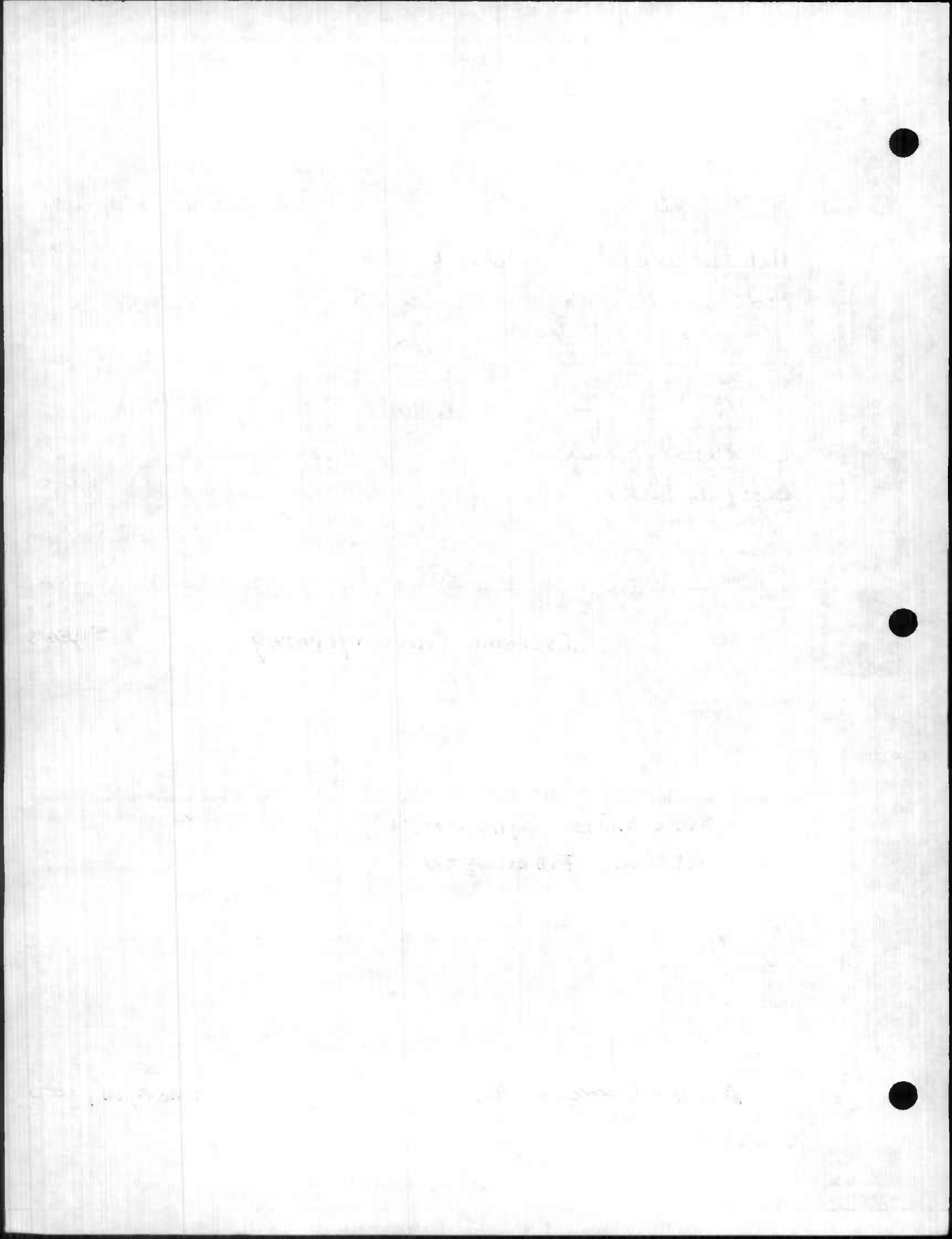
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32932

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARGARET Helen Kelly</b>				2. Date of Death Month <b>OCTOBER</b> Day <b>17</b> Year <b>2000</b>		3. Time of Death <b>11:45AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>HORIZON FRANKFORD NURSING CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
Funeral Director	5. Social Security Number <b>213 05 6044</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>AUGUST 31, 1915</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>	10b. County	10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>5009 FRANKFORD AVE.</b>			10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8YRS.</b> College (1-4 or 5+)		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MACHINE OPERATOR</b>		16b. Kind of Business/Industry <b>LORD BALTIMORE PRESS</b>			
	17. Father's Name (First, Middle, Last) <b>MARTIN CHRIST</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LENA BERTHA STEIN</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>KATHLEEN S. BROWN</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1511 WOODRIDGE LANE SYKEVILLE MARYLAND 21784</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>EVANS FUNERAL CHAPEL - 0018, BELAIR, P.A.</b>		20c. Location - City or Town, State <b>FOREST HILL MARYLAND</b>		20d. Date <b>2000</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>EVANS CHAPEL OF MEMORIES 21234 8800 HARFORD ROAD PARKVILLE MARYLAND</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>SEPSIS</b> Due to (or as a consequence of):  <b>CACHEXIA</b> Due to (or as a consequence of):  <b>RHEUMATOID ARTHRITIS</b> Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D41291</b>		29d. Date signed (Month, Day, Year) <b>OCTOBER 18, 2000</b>		
30. Name and address of person who completed cause of death (Item 23b) (Type, Print) <b>DR. JONATHAN GITTER 21 CROSSROADS DR. OWINGS MILLS, MD.</b>								
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature 						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

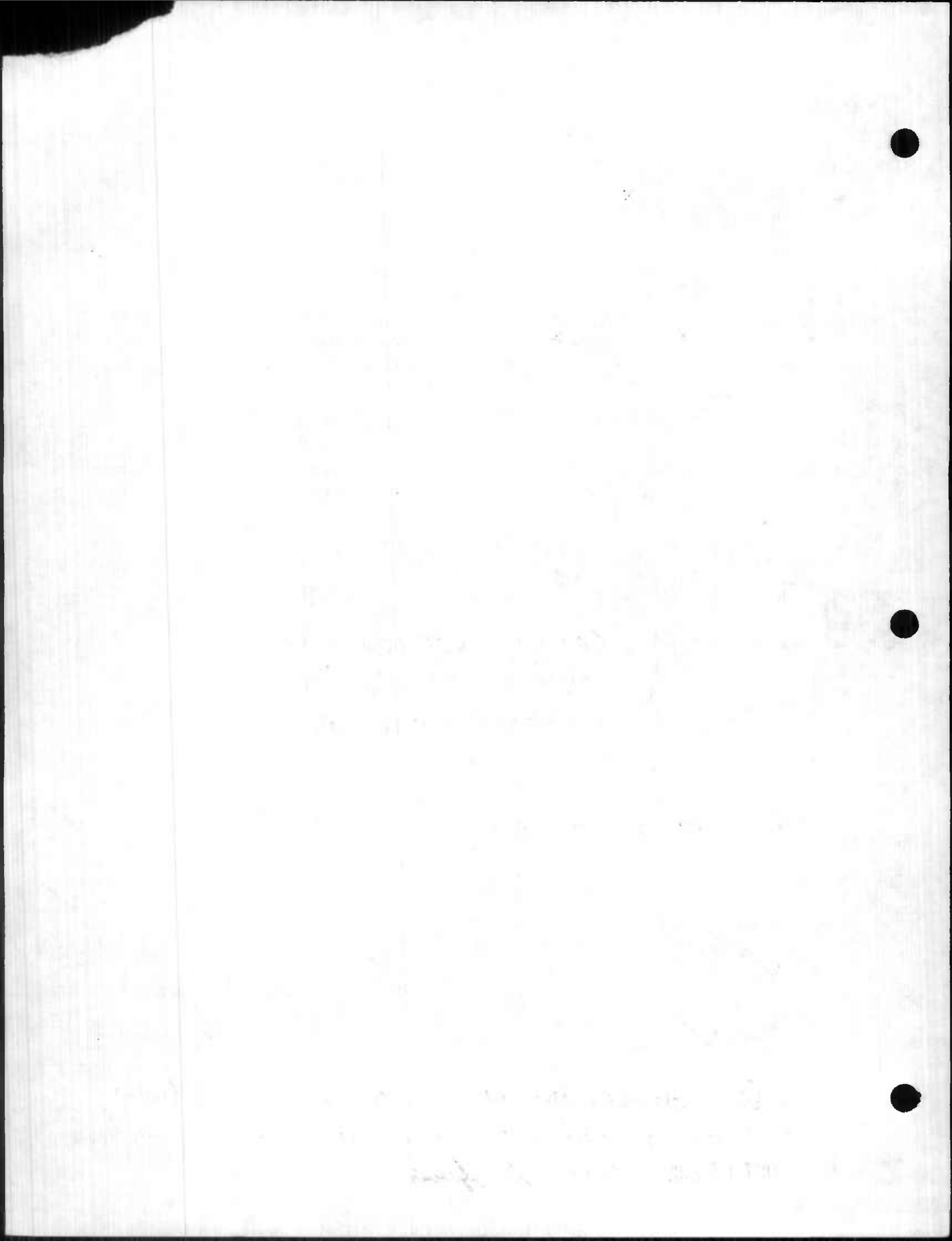
00 32933

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Michael L. Kaitis				2. Date of Death Month 10 Day 12 Year 2000				3. Time of Death 5:40 pm	
	4a. Facility Name (If not institution, give street and number) Heritage Nursing Home				4b. City, Town, or Location of Death Dundalk				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 198-10-3059		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 88 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) 04/25/1912		9. Birthplace (State or Foreign Country) Greece		10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
	10e. Street and Number 727 Ponca Street				10f. Zip Code 21224				10g. Citizen of What Country? United States	
To Be Completed by Physician/Medical Examiner	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salesman				16b. Kind of Business/Industry Sales-Restaurant Equipment			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Leonidas Kaitis				18. Mother's Name (First, Middle, Maiden Surname) Argyrio Cladias					
	19a. Informant's Name/Relationship (Type, Print) Despina Kaitis Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 727 Ponca Street, Baltimore, MD 21224					
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Greek Orthodox Cemetery				20c. Location - City or Town, State 10/16/00 Baltimore, MD	
	21. Signature of Funeral Service Licensee Robert J. Bradley				22. Name and Address of Facility Bradley-Ashton-Matthews Funeral Home, Inc. 2134 Willow Spring Road Dundalk, MD 21222					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HEART FAILURE Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. DIABETES MELLITUS Due to (or as a consequence of): d. DEMENTIA								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. FAILURE TO THRIVE								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M	
	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Sarginder LeTulle MD				29c. License number D 27188	
	29d. Date signed (Month, Day, Year) 10/13/00				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Sarginder LeTulle 2 Mariner Place Baltimore MD 21222					
State Registrar	31. Date filed (Month, Day, Year) OCT 18 2000				32. Registrar's Signature Sarginder LeTulle					

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32934

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LOUIS EDWARD KREINER SR

2. Date of Death

October 16, 2000 Year

3. Time of Death

2:20AM

4a. Facility Name (If not institution, give street and number)

Stella Maris Hospice

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

217-18-5313

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

# Under 1 Year

Months Days

# Under 24 Hrs.

Hours Min.

8. Date of Birth

January 4, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

44 Acorn Circle

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Meat Manager

16b. Kind of Business/Industry

Grocery

17. Father's Name (First, Middle, Last)

John Kreiner

18. Mother's Name (First, Middle, Maiden Sumame)

Katherine Gousman

19a. Informant's Name/Relationship (Type, Print)

Louis E Kreiner Jr

Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2334 Dale Drive Falls Church, Virginia 22043

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer

Date

10-19-00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home Inc.  
6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

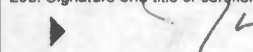
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D43725

29d. Date signed (Month, Day, Year)

10/17/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

OCTOBER 16, 2000 2:20 a.m.

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

LOUIS KREINER, SR.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32935

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) GLORIA B. MAAS					2. Date of Death Month Day Year October 15 2000		3. Time of Death 3:50 AM					
	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital Center					4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore					
Funeral Director	5. Social Security Number 213-80-3193		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Aug 16, 1928		9. Birthplace (State or Foreign Country) Alaska				
	Usual Residence of Decedent												
10a. State MD		10b. County		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 1539 Williams Avenue					10f. Zip Code 21221		10g. Citizen of What Country? USA						
11. Marital Status unk 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4 or 5+) unk					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) home health care			16b. Kind of Business/Industry unk					
17. Father's Name (First, Middle, Last) unk					18. Mother's Name (First, Middle, Maiden Surname) unk								
19a. Informant's Name/Relationship (Type, Print) Franklin Square Hospital					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9000 Franklin Square Drive Baltimore, MD 21237								
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State						
21. Signature of Funeral Service Licensee Ronald S. Wade, Director					22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Metastatic Lung Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.										Approximate Interval Between Onset and Death 5 months			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)										
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier Kevin Brewster, D.O.					29c. License number H0055845		29d. Date signed (Month, Day, Year) 10/15/00						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin Brewster 9000 Franklin Square Drive Baltimore Maryland 21237													
31. Date filed (Month, Day, Year) Oct 18 2000			32. Registrar's Signature Kevin B Sparks										

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Maas, Gloria



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item # 10e,23b,23II,24a, G788,10/27/00,per Dr,FH,Ga

Certificate of Death

Reg. No.

00 32936

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WANDA MARIKLE		2. Date of Death Month: OCTOBER Day: 14 Year: 2000		3. Time of Death 07:05								
	4a. Facility Name (If not institution, give street and number) Levindale Nursing Home		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A								
Funeral Director	5. Social Security Number 042-09-3411	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 88 Yrs.	8. Date of Birth (Month, Day, Year) September 4, 1912	9. Birthplace (State or Foreign Country) Massachusetts								
	Usual Residence of Decedent												
To Be Completed by Funeral Director	10a. State Maryland	10b. County N/A	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
	10e. Street and Number 310 Ridgemed Road <del>4415 Wickford Road</del>		10f. Zip Code 21210		10g. Citizen of What Country? USA								
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:								
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home								
	17. Father's Name (First, Middle, Last) John Shellow		18. Mother's Name (First, Middle, Maiden Surname) Zofia Madej										
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Helen M. Passano		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR 3925 Linkwood Road Baltimore, Maryland 21210										
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Greenmount Cemetery		20c. Location - City or Town, State 10-18-00 Baltimore, Maryland								
	21. Signature of Funeral Service Licensee <i>Dennis Stephen Kenake</i>		22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212										
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="1"> <tr> <td rowspan="4">                 Immediate Cause (Final disease or condition resulting in death)                   Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a. CORONARY ARTERY DISEASE</td> <td>2 YEAR</td> </tr> <tr> <td>b. <del>DECUBITUS</del></td> <td><del>1 YEAR</del></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>					Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CORONARY ARTERY DISEASE	2 YEAR	b. <del>DECUBITUS</del>	<del>1 YEAR</del>	c.		d.
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CORONARY ARTERY DISEASE	2 YEAR											
	b. <del>DECUBITUS</del>	<del>1 YEAR</del>											
	c.												
	d.												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Possible Respiratory Failure													
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown													
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No													
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No													
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined													
28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No													
28d. Describe how injury occurred 28e. Location (Street and Number or Rural Route Number, City or Town, State)													
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. Signature and title of certifier <i>Dennis M. Eversley M.D.</i>													
29c. License number D 54739													
29d. Date signed (Month, Day, Year) OCTOBER 14 <sup>th</sup> 2000													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W. BELVEDERE AVENUE, BALTIMORE MARYLAND 21215													
31. Date filed (Month, Day, Year) OCT 18 2000													
32. Registrar's Signature <i>Dennis M. Eversley</i>													

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32937

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LUCILE KEMP MUELLER</b>				2. Date of Death Month <b>October</b> Day <b>16</b> Year <b>2000</b>		3. Time of Death <b>6:15PM</b>
	4a. Facility Name (If not institution, give street and number) <b>Brightwood Nursing Home</b>				4b. City, Town, or Location of Death <b>Lutherville</b>		4c. County of Death <b>Baltimore</b>
Funeral Director	5. Social Security Number <b>212-30-5642</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>94</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 31, 1906</b>	9. Birthplace (State or Foreign Country) <b>Tennessee</b>
	Usual Residence of Decedent						
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>1917 Ruxton Road</b>				10f. Zip Code <b>21204</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> Collage (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teacher</b>		16b. Kind of Business/Industry <b>Baltimore County Board of Ed.</b>	
17. Father's Name (First, Middle, Last) <b>Thayer Alfonso Kemp</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Susan Berthel Wiggins</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mary M. Greenwood DTR</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1917 Ruxton Road Baltimore, Maryland 21204</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Moreland Memorial Park</b>		20c. Location - City or Town, State <b>10-20-00 Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee <i>Bennis A. Hyslop-Kenakis</i>				22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Respiratory failure</b> Due to (or as a consequence of):  b. <b>Atherosclerotic multi-infarct dementia years</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypothyroidism</b> <b>Osteoporosis</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <i>Laura M Mumford</i>				29c. License number <b>D18410</b>		29d. Date signed (Month, Day, Year) <b>10/17/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Laura M Mumford MD 10755 Falls Rd Lutherville, MD 21093</b>							
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>				32. Registrar's Signature <i>Laura B Sparks</i>			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32938

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harold E. Martin				2. Date of Death Month Day Year October 6 2000				3. Time of Death 9:30 pm	
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie				4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 316-24-0028		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 68 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 2, 1932		9. Birthplace (State or Foreign Country) Indiana	
	Usual Residence of Decedent				10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Odenton	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number 539 Saltoun Avenue				10f. Zip Code 21113	
	10g. Citizen of What Country? USA				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1953-77	
	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) SFC				16b. Kind of Business/Industry US Army				17. Father's Name (First, Middle, Last) Theodore Martin	
	18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Hobbs				19a. Informant's Name/Relationship (Type, Print) Mary Edna Martin (Wife)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 539 Saltoun Avenue, Odenton, MD 21113	
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland Veterans Cem.				20c. Location - City or Town, State Crownsville, MD	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. GASTROINTESTINAL BLEEDING Due to (or as a consequence of): b. CORONARY ARTERY DISEASE Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):	
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier Barbara Kalazny M.D.				29c. License number D 35436				29d. Date signed (Month, Day, Year) 10.11.2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BARBARA KALAZNY M.D. 1132 ANNAPOLIS RD, ODENTON, MD 21113				31. Date filed (Month, Day, Year) OCT 18 2000				32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Items 1,17,18 per phy.,fd11/08/00dht  
film #789

State of Maryland / Department of Health and Mental Hygiene

00 32939

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Irving K. Meginnis</u> Irving P. Meginnis						2. Date of Death Month Day Year Oct. 14, 2000		3. Time of Death 9A.M.				
	4a. Facility Name (If not Institution, give street and number) 8175 Bodkin Ave.						4b. City, Town, or Location of Death Pasadena		4c. County of Death Anne Arundel				
Funeral Director	5. Social Security Number 213-03-5193		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (in yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) 2-21-1916		9. Birthplace (State or Foreign Country) Maryland				
	Usual Residence of Decedent												
10a. State MD.		10b. County Anne Arundel		10c. City, Town or Location Pasadena				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
10e. Street and Number 8175 Bodkin Ave.				10f. Zip Code 21122		10g. Citizen of What Country? U.S.A.							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Photographer			16b. Kind of Business/Industry Owner McGinnis Old Films						
17. Father's Name (First, Middle, Last) William B. Meginnis Paul Meginnis						18. Mother's Name (First, Middle, Maiden Surname) Unknown Ida Kohler							
19a. Informant's Name/Relationship (Type, Print) Casimer B. Zebzon (Brother-in Law						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8175 Bodkin Ave. Pasadena, MD. 21122							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Holy Cross Cem.		20c. Location - City or Town, State 10-17-00 Balto., MD.							
21. Signature of Funeral Service Licensee 						22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Rd. Pasadena, MD. 21122							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>pneumonia</u> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death days			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>dementia, cachexia</u>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
										24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
				28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29c. License number D41955		29d. Date signed (Month, Day, Year) 10-14-00	
29b. Signature and title of certifier 													
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rebecca Elton MD 479 Jumpers Hole Rd Severna Park MD 21146													
31. Date filed (Month, Day, Year) OCT 18 2000				32. Registrar's Signature 									

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32940

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA MINNIE MINNICK

2. Date of Death

October 14 2000

3. Time of Death

23:05

4e. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

218-18-8746

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 14 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1416 Sussex Road

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Business Owner

16b. Kind of Business/Industry

Plasta Craft

17. Father's Name (First, Middle, Last)

Charles Eckles

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Heck

19a. Informant's Name/Relationship (Type, Print)

Robert N. Minnick /husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1416 Sussex Road Baltimore MD 21221

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery 10/18/2000

Date

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex

300 MACE AVE. Baltimore Md. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CANCER OF LUNG

Due to (or as a consequence of):

10 years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CRONIC OBSTRUCTIVE LUNG DISEASE

Due to (or as a consequence of):

15 years

c. RESPIRATORY FAILURE

Due to (or as a consequence of):

3 days

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

Dr. THOMAS NEDUMTHOTT ATHIL

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

October 14 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 SOUTH HANOVER BALTIMORE 25 MD

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

Benjamin S Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32941

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES JOHN NIXON</b>				2. Date of Death Month Day Year <b>October 16, 2000</b>				3. Time of Death <b>11:15 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Long Green Center-Genesis</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>220-11-8065</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>93</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 20, 1907</b>		9. Birthplace (State or Foreign Country) <b>England</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Brooklandville</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>827 Hillside Road</b>				10f. Zip Code <b>21022</b>		10g. Citizen of What Country? <b>England</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 years</b> College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Manager</b>				16b. Kind of Business/Industry <b>Lumber</b>	
	17. Father's Name (First, Middle, Last) <b>Charles Nathan Nixon</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ann Ley Ede</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Dorothy Nixon (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>827 Hillside Road Brooklandville, Maryland 21022</b>					
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Crematory</b>		20c. Location - City or Town, State <b>10-18-00 Baltimore, Maryland</b>					
	21. Signature of Funeral Service Licensee <b>George J. Piernie</b>				22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Failure to Thrive</b> Due to (or as a consequence of): <b>b. Multifactorial Dementia</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b> Due to (or as a consequence of):									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>D17118</b>		29d. Date signed (Month, Day, Year) <b>Oct 17, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Paul Schwartz M.D. 115 E. Melrose Ave 21212</b>										
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature <b>[Signature]</b>								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Amend Item 29c, per FR, 11/21/00dhhb

6789

00 32942

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Gladys B. Nash				2. Date of Death Month Day Year 9 6 2000		3. Time of Death 6:00 P.M.	
	4a. Facility Name (If not institution, give street and number) 517 Opus Avenue				4b. City, Town, or Location of Death Capitol Heights		4c. County of Death Prince Georges	
Funeral Director	5. Social Security Number 577-50-3417		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12 24 1930	9. Birthplace (State or Foreign Country) Georgia
	Usual Residence of Decedent							
10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Capitol Heights			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 517 Opus Avenue		10f. Zip Code 20743		10g. Citizen of What Country? U.S.A.				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Service Worker			16b. Kind of Business/Industry Private	
17. Father's Name (First, Middle, Last) Isaiah Barksdale				18. Mother's Name (First, Middle, Maiden Surname) Hattie D. Wynn				
19a. Informant's Name/Relationship (Type, Print) Charles Nash/ Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 517 Opus Avenue Capitol Heights, MD. 20743				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		Date 9/12/2000		20c. Location - City or Town, State Brentwood, MD.
21. Signature of Funeral Service Licensee  cc0348				22. Name and Address of Facility Latney Funeral Home 3831 Georgia Ave. N.W. Washington D.C. 20011				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a. Breast Mass Due to (or as a consequence of): b. Atrial Fibrillation Due to (or as a consequence of): c. Hypertension Due to (or as a consequence of): d. Hyper Cholesterolemia								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
				28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and Title of certifier 				29c. License number D0041881 <del>19069</del>		29d. Date signed (Month, Day, Year) 10/5/00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Allen S. Rogers, MD Kaiser Permanente 1011 North Capitol St. N.E. Wash. D.C. 20002								
31. Date filed (Month, Day, Year) OCT 06 2000				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

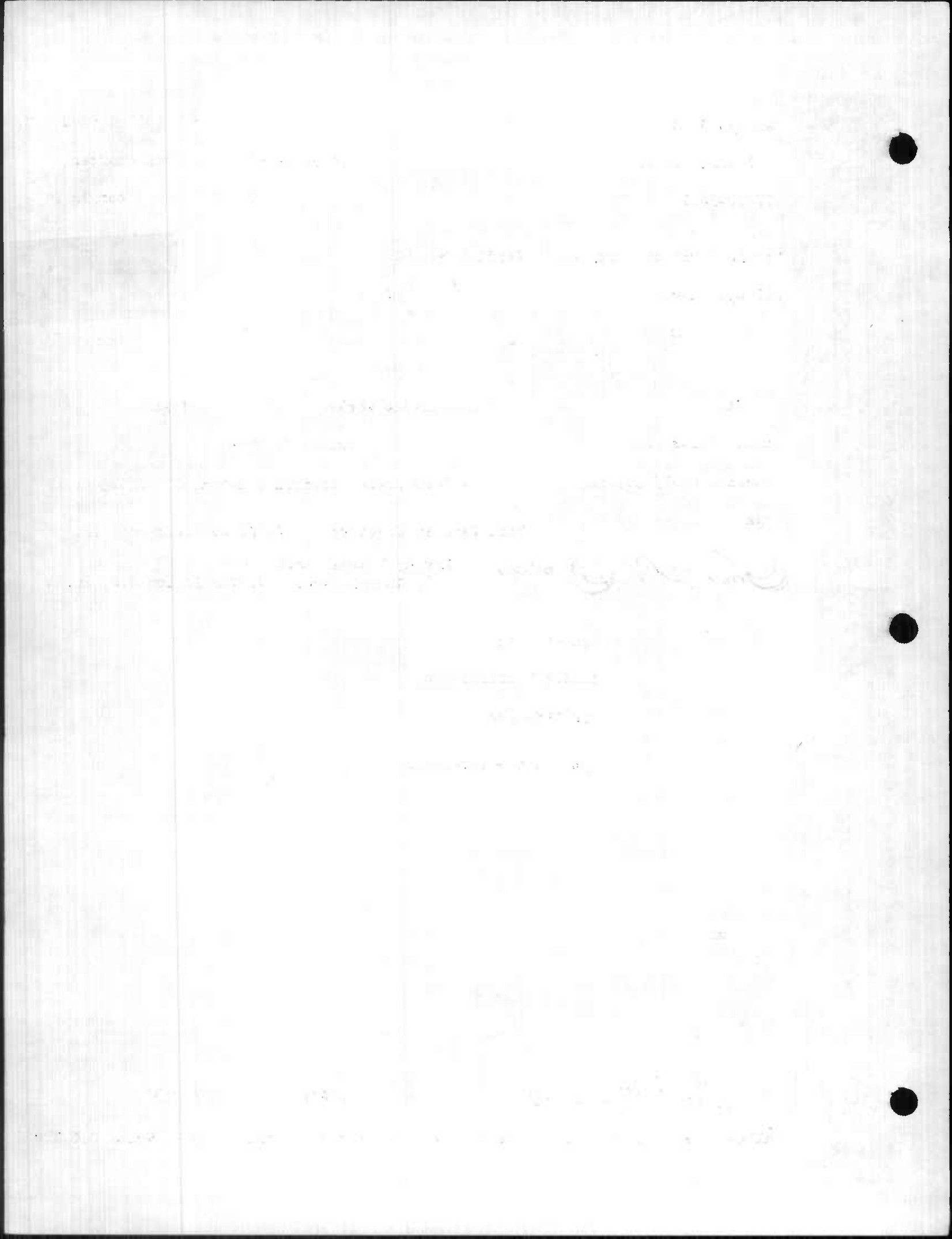
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32943

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) William P. Neighoff				2. Date of Death Month Day Year October 12 2000		3. Time of Death 6:30 AM	
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital				4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 214-12-1596		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) 8-16-1921	
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD.		10b. County Anne Arundel		10c. City, Town or Location Pasadena	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 611 Riverside Dr.		10f. Zip Code 21122		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter & Maintenance		16b. Kind of Business/Industry A.A. County Schools		17. Father's Name (First, Middle, Last) William P. Neighoff, Sr.	
	18. Mother's Name (First, Middle, Maiden Surname) Sarah Fefel		19a. Informant's Name/Relationship (Type, Print) Mary T. Neighoff (Wife)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Riverside Dr. Pasadena, MD. 21122		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Mem. Park		20c. Location - City or Town, State Glen Burnie, MD.		21. Signature of Funeral Service Licensee John F. Collins		22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Rd. Pasadena, MD. 21122	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ruptured abdominal aortic aneurysm Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
	28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Kofi Romiley, MD		29c. License number D48006		29d. Date signed (Month, Day, Year) October 12 <sup>th</sup> , 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kofi Romiley, 301 Hosp. Dr., Glen Burnie, MD 21061		31. Date filed (Month, Day, Year) OCT 18 2000		32. Registrar's Signature Benita B. Sparks		33. Date of Death October 12 2000	

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 32944

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EMMA JANE PATTERSON				2. Date of Death Month Day Year OCTOBER 6, 2000				3. Time of Death 10:45 PM						
	4a. Facility Name (If not institution, give street and number) 523 N. Fulton Avenue				4b. City, Town, or Location of Death Baltimore				4c. County of Death						
Funeral Director	5. Social Security Number 216-24-1993		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) Mar 26, 1926		9. Birthplace (State or Foreign Country) MD		
	Usual Residence of Decedent														
10a. State MD		10b. County		10c. City, Town or Location Baltimore						10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 523 N. Fulton Avenue				10f. Zip Code 21223				10g. Citizen of What Country? USA							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: black			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 0				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) domestic				16b. Kind of Business/Industry housecleaning							
17. Father's Name (First, Middle, Last) Robert J. Eskridge								18. Mother's Name (First, Middle, Maiden Surname) Elisa A. Jackson							
19a. Informant's Name/Relationship (Type, Print) Spring Ferguson/daughter								19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 523 N. Fulton Avenue Baltimore, MD 21223							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)				Date		20c. Location - City or Town, State					
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201											
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e. Cirrhosis of liver Due to (or as a consequence of): b. Hepatitis C Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last														Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal failure Hypertension										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred					
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier Thomas A. Lynch MD				29c. License number D42196				29d. Date signed (Month, Day, Year) October 12, 2000			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Thomas Lynch 301 St. Paul Suite 907 Baltimore MD 21202															
31. Date filed (Month, Day, Year) OCT 18 2000				32. Registrar's Signature Benjamin A. Sparks											

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

00 32945

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Martin R. Peters</u>				2. Date of Death Month <u>Oct</u> Day <u>16</u> Year <u>2000</u>				3. Time of Death <u>5:39pm</u>	
	4e. Facility Name (If not institution, give street and number) <u>Hood Samaritan Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore</u>				4c. County of Death	
Funeral Director	5. Social Security Number <u>212-30-9514</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		Age (In yrs. last birthday) <u>65</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Oct. 17 1934</u>		9. Birthplace (State or Foreign Country) <u>Maryland</u>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <u>Md</u>		10b. County <u>Baltimore</u>		10c. City, Town or Location <u>Parkville</u>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <u>2801 Willoughby Rd.</u>				10f. Zip Code <u>21234</u>		10g. Citizen of What Country? <u>USA</u>			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4or 5+) <u>4</u>				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>credit manager</u>			16b. Kind of Business/Industry <u>Alkin Tractor</u>		
	17. Father's Name (First, Middle, Last) <u>Martin R. Peters, Sr.</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Pauline G. Sittka</u>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>Joan Peters wife</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2801 Willoughby Rd. Baltimore, Md 21234</u>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Holy Redeemer Come.</u>		Date <u>Oct. 19 2000</u>		20c. Location - City or Town, State <u>Baltimore, Md</u>			
	21. Signature of Funeral Service Licensee <u>Krista S. Wells</u>				22. Name and Address of Facility <u>EVANS Funeral Chapel</u> <u>8800 Harford Rd. Baltimore, Md 21234</u>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown									
23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23d. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
23e. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>Dr. Timothy Kroke MD</u>		29c. License number <u>D44296</u>		29d. Date signed (Month, Day, Year) <u>10/18/2000</u>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Dr. Timothy Kroke 10755 Falls Rd. Suite 201 Baltimore, Md</u>										
31. Date filed (Month, Day, Year) <u>OCT 18 2000</u>		32. Registrar's Signature <u>Beverly G. Sparks</u>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

- a. ischemic cardiomyopathy  
Due to (or as a consequence of):
- b. coronary artery disease  
Due to (or as a consequence of):
- c. hypercholesterolemia  
Due to (or as a consequence of):
- d.

Approximate  
Interval Between  
Onset and Death72 years

Handwritten text, mostly illegible due to fading. Some words like "The" and "and" are visible.

The year 1871 was a  
very important year for  
the history of the world.

X

Handwritten text at the bottom of the page, including a signature and date.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32946

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARVIN PATTERSON</b>		2. Date of Death Month Day Year <b>OCTOBER 14 2000</b>		3. Time of Death <b>7:50A</b>
	4a. Facility Name (If not institution, give street and number) <b>Bon Secours Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>217-62-1899</b>	6. Sex <b>1 M 2 F</b>	7. Age (In yrs. last birthday) <b>46</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>April 27, 1954</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <b>1 X Yes 2 No</b>		10e. Street and Number <b>2409 Baker St.</b>		10f. Zip Code <b>21216</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <b>1 Never Married 2 X Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 X No</b>	
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 Yes 2 X No Specify:</b>		14. Race - American Indian, Black, White, etc. <b>Specify: Afro-American</b>		15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 0 College (1-4 or 5+)</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Heavy Equipment Driver</b>		16b. Kind of Business/Industry <b>Construction</b>			
17. Father's Name (First, Middle, Last) <b>unk.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Sylvia Patterson</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mr. Thomas Fair</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2409 Baker St. Balto. Md. 21216</b>			
20a. Method of Disposition <b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion</b>		20c. Location - City or Town, State <b>1918/2000 Lansdowne, Md.</b>	
21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>		22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>			
23a. Pertinent. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Bilateral Pneumonia</b> Due to (or as a consequence of): <b>Human Immunodeficiency Syndrome</b> Due to (or as a consequence of): <b>170 Intrauterine drug abuse</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death			
23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>		24a. Was an autopsy performed? <b>1 Yes 2 X No</b>			
24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>		25. Was case referred to medical examiner? <b>1 Yes 2 X No</b>			
26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>		27. Manner of Death <b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>			
28a. Date of injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>		29b. Signature and title of certifier <b>Joseph L. Russ</b>			
29c. License number <b>D17537</b>		29d. Date signed (Month, Day, Year) <b>10-14-2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DARSHAN S. SALUJA 1600 W. MOUNT Royal Ave, Balto 21217</b>					
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature <b>[Signature]</b>			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32947

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Edward Pinkerton, Sr.				2. Date of Death Month Day Year 10/11/2000		3. Time of Death 10:13pm	
	4a. Facility Name (If not institution, give street and number) Catonsville Commons Nursing Home				4b. City, Town, or Location of Death Catonsville		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 213-09-2043	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 82	8. Date of Birth (Month, Day, Year) 06/25/1918	9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Glen Burnie	
10e. Street and Number 7900 Benesch Circle Apt. # 788				10f. Zip Code 21060		10g. Citizen of What Country? United States		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine Mechanic		16b. Kind of Business/Industry Food Production				
17. Father's Name (First, Middle, Last) John Henry Pinkerton				18. Mother's Name (First, Middle, Maiden Surname) Henrietta Augusta Kruemell				
19a. Informant's Name/Relationship (Type, Print) John Edward Pinkerton, Jr.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4508 Maple Ave. Halethorpe, MD 21227				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory		20c. Location - City or Town, State 10/12/00 Catonsville, MD				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, Maryland 21227						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Degenerative joint disease Prostate cancer								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 		29c. License number D-40524		29d. Date signed (Month, Day, Year) October 12, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. OCHANAY		7845 Oakwood Road Suite 205 Glen Burnie, MD 21061						
31. Date filed (Month, Day, Year) OCT 18 2000		32. Registrar's Signature 						

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 32948

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anna Kathryn Richter

2. Date of Death

10 / 04 / 2000

3. Time of Death

7:35

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2211 West Rogers Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

City

5. Social Security Number

214-40-5601

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

97

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

5/15/1903

9. Birthplace (State or Foreign Country)

Balto. City

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2211 West Rogers Avenue

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6 years

College (1-4 or 5+)

N/A

18a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Housewife

18b. Kind of Business/Industry

Her own home

17. Father's Name (First, Middle, Last)

Charles Creamer

18. Mother's Name (First, Middle, Maiden Surname)

Mary M. Hoffman

19a. Informant's Name/Relationship (Type, Print)

Melvin Richter (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7018 Mt. Vista Rd, Kingsville, MD 21087

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

10/7/00

20c. Location - City or Town, State

Parkville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

E.F. Lassahn Funeral Home  
11750 Belair Rd. Kingsville, Md 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE RESPIRATORY FAILURE

Due to (or as a consequence of):

ACUTE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. END-STAGE CHRONIC OBSTRUCTIVE LUNG DISEASE

Due to (or as a consequence of):

YEARS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARDIOMYOPATHY, ATRIAL FIBRILLATION,  
CHRONIC RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-19425

29d. Date signed (Month, Day, Year)

10/05/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT E. ROBY, M.D. - 2211 W. ROGERS AVE, BALTO, MD 21209

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

State  
Registrar

Exp. 10-4-00

Richter, Ann K.  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32949

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Regina Reitz

2. Date of Death

October 16 2000

3. Time of Death

3:40 PM

4a. Facility Name (If not institution, give street and number)

230 Compass Rd

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Essex

Funeral  
Director

5. Social Security Number

213-28-9830

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

8. Date of Birth

May 11, 1933

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

230 Compass Rd.

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12 yrs.

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Law Firm

17. Father's Name (First, Middle, Last)

Albert Szamborski

18. Mother's Name (First, Middle, Maiden Surname)

Mary Biedronski

19a. Informant's Name/Relationship (Type, Print)

Joseph Reitz husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

230 Compass Rd. Essex, Md. 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St Stanislaus

Date

Oct 19 2000

20c. Location - City or Town, State

Dundalk, Md.

21. Signature of Funeral Service Licensee

Anthony Connelly

22. Name and Address of Facility

Connelly Funeral Home of Dundalk, P.A.  
7110 Sollers Point Rd. Dundalk, Md. 21222

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hepatocellular Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cirrhosis

Due to (or as a consequence of):

10 years

c. Hepatitis C

Due to (or as a consequence of):

30 years

d. Blood transfusions 1960's

30 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. O'Mahony

29c. License number

D 46389

29d. Date signed (Month, Day, Year)

October 18, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. O'Mahony, M.D. 301 St Paul Baltimore MD 21202

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

Geneva B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00132950

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bernard</b>		2. Date of Death Month <b>OCTOBER</b> Day <b>13</b> Year <b>2000</b>		3. Time of Death <b>1130 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>216-62-5604</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>35</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth Month <b>Nov.</b> Day <b>28</b> Year <b>1964</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>Maryland</b>		10b. County <b>N/A</b>
	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10a. Street and Number <b>1113 Wilmot Ct.</b>		10f. Zip Code <b>21202</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>Negro</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Bricklayer</b>	
16b. Kind of Business/Industry <b>Private Co.</b>		17. Father's Name (First, Middle, Last) <b>Bernard Rice Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Victoria Rice</b>	
19a. Informant's Name/Relationship (Type, Print) (mother) <b>Ms. Victoria Rice</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1113 Wilmot Ct. Balto. Md. 21202</b>			
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Crematory</b>		20c. Location - City or Town, State <b>Balto. Md.</b>	
21. Signature of Funeral Service Licensee <b>Joseph L. Russ</b>		22. Name and Address of Facility <b>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Acute Respiratory Distress Syndrome</b> Due to (or as a consequence of): b. <b>Pneumocystis pneumonia</b> Due to (or as a consequence of): c. <b>Acquired Immunodeficiency Syndrome</b> Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death <b>24 hours</b> <b>1 week</b> <b>5 years</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cryptogenic liver failure</b> <b>Pancreatitis</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <b>2</b> No	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. Signature and title of certifier <b>Gail Berkenblit MD</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>October 13, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Gail Berkenblit MD 600 N. WOLFE STREET BALTIMORE MD 21287</b>					
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32951

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HARRY ROBERTS

2. Date of Death

October 9, 2000

3. Time of Death

10:20 AM

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral  
Director

5. Social Security Number

219-26-9776

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

7-19-1936

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

501 W. Franklin St.

10f. Zip Code

21201

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

BWI Airport

17. Father's Name (First, Middle, Last)

Joseph Roberts

18. Mother's Name (First, Middle, Maiden Surname)

Mabel Cheek

19a. Informant's Name/Relationship (Type, Print)

James Roberts - Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 Corporate Drive Apt 11 Balt Co.

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 10-12-00 Baltimore Md.

Date

20c. Location - City or Town, State

Baltimore Md.

21. Signature of Funeral Service Licensee

Wesley Chang

22. Name and Address of Facility

CHAVIS FH 2007 EASTERN AVE BALTO-21223

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Renal Disease

Due to (or as a consequence of):

b. Diabetes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

H/O Gastrointestinal Bleeding, Hypertension, Seizure disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner2 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Saluja

29c. License number

D17537

29d. Date signed (Month, Day, Year)

10.9.2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Darshan Saluja, M.D. 1600 W. Mt. Royal Ave. Balt., Md. 21217

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Harry Roberts.  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32952

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rhonda L. Robinson				2. Date of Death Month: October Day: 16 Year: 2000				3. Time of Death 5:30 AM	
	4a. Facility Name (If not institution, give street and number) 330 Green Mountain Court				4b. City, Town, or Location of Death Pasadena				4c. County of Death Anne Arundel Co.	
Funeral Director	5. Social Security Number 216-96-5986		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 32 Yrs.		8. Date of Birth (Month, Day, Year) 10-26-1967		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State MD.		10b. County Anne Arundel		10c. City, Town or Location Pasadena	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 330 Green Mountain Ct.				10f. Zip Code 21122	
	10g. Citizen of What Country? U.S.A.				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 1	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Admin. Tech.				16b. Kind of Business/Industry U.S. Govt.				17. Father's Name (First, Middle, Last) Richard Whorten	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) Lillian Gray				19a. Informant's Name/Relationship (Type, Print) Raymond T. Robinson (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 330 Green Mountain Ct. Pasadena, MD, 21122	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):				20b. Place of Disposition (Name of cemetery, crematory or other place) Glen Haven Memorial Park				20c. Location - City or Town, State 10/21/2000 Glen Burnie, Md.	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Rd. Pasadena, MD, 21122				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of Cervix Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day Year)				28b. Time of Injury M				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i>				29c. License number 024356	
To Be Completed by Physician/Medical Examiner	29d. Date signed (Month, Day, Year) October 17, 2000				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wm C Waterscheid MD Stages Cancer Center 900 Catoe Ave Baltimore MD 21229				31. Date filed (Month, Day, Year) OCT 18 2000	
	32. Registrar's Signature <i>[Signature]</i>				33. State Registrar DCHM 16 Rev 6/95				ORIGINAL	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#9perFH, #26 perPhyG788 10/18/2000 EW

## Certificate of Death

Reg. No.

00 32953

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Willie S. Satterwhite</u>				2. Date of Death Month <u>10</u> Day <u>6</u> Year <u>2000</u>		3. Time of Death <u>12:15 am</u>		
	4a. Facility Name (If not institution, give street and number) <u>Baltimore VA Medical Center</u>				4b. City, Town, or Location of Death <u>Baltimore, MD</u>		4c. County of Death <u>Baltimore City</u>		
Funeral Director	5. Social Security Number <u>212-12-7756</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>77</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>March 07, 1923</u>	9. Birthplace (State or Foreign Country) <u>Wake Forest NC</u>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <u>MD</u>		10b. County <u>Baltimore City</u>		10c. City, Town or Location <u>Baltimore</u>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <u>3014 Roselind Avenue</u>				10f. Zip Code <u>21215</u>		10g. Citizen of What Country? <u>USA</u>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <u>un</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11th grade</u>		College (1-4 or 5+) <u>N/A</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Truck Driver</u>		16b. Kind of Business/Industry <u>Loch Raven Library Towson</u>		
	17. Father's Name (First, Middle, Last) <u>Sam Satterwhite</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Elizabeth Satterwhite</u>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>Vernice Satterwhite - Wife</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3014 Rosalind Avenue Baltimore, Md 21215</u>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Woodlawn Cemetery</u>		Date <u>10-11-00</u>		20c. Location - City or Town, State <u>Balto Co, Md</u>		
	21. Signature of Funeral Service Licensee <u>John March</u>				22. Name and Address of Facility <u>March F/H West</u> <u>4300 Wabash Avenue Baltimore, Md 21215</u>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>a. Acute Myelocytic Leukemia Crisis</u> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.							Approximate Interval Between Onset and Death <u>unknown</u>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <u>JC Greenawalt MD</u>				29c. License number <u>P14696</u>	
29d. Date signed (Month, Day, Year) <u>October 06 2000</u>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>JC Greenawalt MD / UMMS, S. Greene St. Baltimore, MD</u>					
31. Date filed (Month, Day, Year) <u>OCT 18 2000</u>		32. Registrar's Signature <u>Pinna B Sparks</u>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32954

amend item 23a, pt II, 28a, b, c, d, e, f per me G788 10/19/00 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ALAN JOSEPH SEBREE</b>				2. Date of Death Month Day Year <b>SEPTEMBER 27, 2000</b>				3. Time of Death <b>17:10 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>25 PENDRAGON COURT</b>				4b. City, Town, or Location of Death <b>REISTERSTOWN</b>				4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>218-48-4518</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>52</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct 6, 1947</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Reisterstown</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>25 Pendragon Court</b>				10f. Zip Code <b>21136</b>				10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>disabled</b>				16b. Kind of Business/Industry <b>none</b>			
17. Father's Name (First, Middle, Last) <b>Gordon F. Sebree</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian Conner</b>							
19a. Informant's Name/Relationship (Type, Print) <b>O.C.M.E.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>111 Penn Street Baltimore, MD 21201</b>							
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. PONTINE HEMORRHAGE COMPLICATING SUBDURAL HEMORRHAGE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ACUTE AND CHRONIC ALCOHOL USE</b>											
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>found: 9/27/00</b>		28b. Time of Injury <b>found: 4:52 P M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>subject fell</b>	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>residence</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>25 Pendragon Court, Reisterstown, Md.</b>							
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <b>J. M. Tins M.D.</b>				29c. License number <b>O.C.M.E.</b>				29d. Date signed (Month, Day, Year) <b>SEPTEMBER 28, 2000</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>JACK M. TINS M.D. 111 Penn Street, Baltimore, Maryland 21201</b>											
State Registrar		31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature <b>A Sparks</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32955

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Colon Surles		2. Date of Death Month: 10 Day: 14 Year: 00		3. Time of Death 5:00 am
	4a. Facility Name (If not institution, give street and number) University of Maryland Medical System		4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A
Funeral Director	5. Social Security Number 213-28-1103	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 73	8. Date of Birth (Month, Day, Year) 04-26-27	9. Birthplace (State or Foreign Country) SC
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State MD	10b. County NA	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number 1511 N. Bond Street		10f. Zip Code 21213		10g. Citizen of What Country? USA
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 8th Grade College (1-4or 5+): NA		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction		16b. Kind of Business/Industry Construction Co.		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Talon Surles		18. Mother's Name (First, Middle, Maiden Surname) Coral Lee Surles		
	19a. Informant's Name/Relationship (Type, Print) Mariah Brown		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1511 N. Bond Street Baltimore, Maryland 21213		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Voshell Mem. Gardens		20c. Location - City or Town, State 10-20-2000 Dundalk, MD
	21. Signature of Funeral Service Licensee Bladys Waver		22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Polymicrobial Bacteremia Due to (or as a consequence of): Urosepsis/Osteomyelitis Decubitus Ulcers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dementia, Malnutrition				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Andrew Gault		29c. License number P14751		29d. Date signed (Month, Day, Year) Oct. 16, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Gault 22 S. GREENE ST. BALTO, MD 21201					
31. Date filed (Month, Day, Year) OCT 18 2000		32. Registrar's Signature James B. Sparks			

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32956

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) PAULINE SOMERVILLE				2. Date of Death Month Day Year 10 15 00		3. Time of Death 11:00AM	
	4a. Facility Name (If not institution, give street and number) Levindale Nursing Home				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-22-9321		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) April 27, 1921	
	9. Birthplace (State or Foreign Country) North Carolina		10e. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10f. Zip Code 21216		10g. Citizen of What Country? USA		10h. Street and Number 2210 Presbury St.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cafeteria Aide		16b. Kind of Business/Industry Public School		17. Father's Name (First, Middle, Last) Nathan Smith	
	18. Mother's Name (First, Middle, Maiden Surname) Josephine Davis		19a. Informant's Name/Relationship (Type, Print) Ms. Barbara Somerville (daughter)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3917 Dolfield Ave. Balto, Md. 21215		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest		20c. Location - City or Town, State Dwings Mills, Md.		21. Signature of Funeral Service Licensee Joseph L. Russ		22. Name and Address of Facility Joseph L. Russ Funeral Home 2222 W. North Ave. Balto Md. 21216	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION PNEUMONIA Due to (or as a consequence of): b. CVA Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 2 months 6 months		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Denna M. Evelyn M.D.		29c. License number D 54739		29d. Date signed (Month, Day, Year) OCTOBER 16th 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W. Belvedere Avenue, Baltimore Maryland 21215		31. Data filed (Month, Day, Year) - - OCT 18 2000		32. Registrar's Signature A Sparks		State Registrar	

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32957

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Elizabeth Saunders

2. Date of Death

October 13 2000

3. Time of Death

4:25 AM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

217-16-8783

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (Month, Day, Year)

Oct. 6, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Odenton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

372 Baltimore Ave.

10f. Zip Code

21113

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1944-'46

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Herbert E. Knickman

18. Mother's Name (First, Middle, Maiden Surname)

Rose Fisher

19a. Informant's Name/Relationship (Type, Print)

Frederick S. Saunders / Hus.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

372 Baltimore Ave., Odenton, Maryland 21113

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crownsville MD Vet. Cem.

Date

Oct. 16 2000

20c. Location - City or Town, State

Crownsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Kirkley-Ruddick Funeral Home, P.A.

421 Crain Hwy., S.E., Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician:2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D41365

29d. Date signed (Month, Day, Year)

October 13, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George E. Wicks M.D. 301 Hospital Drive, Glen Burnie 21061

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

Mary E. Saunders  
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director









Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32959

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Edith Geneva Staton				2. Date of Death Month Day Year October 14, 2000		3. Time of Death 10:30pm	
	4e. Facility Name (If not institution, give street and number) Eastpoint Nursing & Rehab				4b. City, Town, or Location of Death Eastpoint		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-22-7402		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 82 Yrs.		8. Date of Birth (Month, Day, Year) 3/16/1918	
	9. Birthplace (State or Foreign Country) Tenn.		10a. State MD		10b. County n/a		10c. City, Town or Location Baltimore	
Usual Residence of Decedent								
10a. State MD			10b. County n/a			10c. City, Town or Location Baltimore		
10e. Street and Number 3309 East Pratt Street			10f. Zip Code 21224			10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) 8th			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		
16b. Kind of Business/Industry In own home			17. Father's Name (First, Middle, Last) James Gribble			18. Mother's Name (First, Middle, Maiden Surname) Maude Bryant		
19a. Informant's Name/Relationship (Type, Print) SON Wayne Staton			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 62 Riverview Rd. West, Delta, Pa. 17314					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Crestlawn			20c. Location - City or Town, State 10/18/2000 Baltimore, Maryland		
21. Signature of Funeral Service Licensee Maria B. Zannino			22. Name and Address of Facility Joseph N. Zannino Jr. Funeral Home 263 South Conkling Street, Baltimore, Maryland 21224					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) END STAGE DEMENTIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. FAILURE TO THRIVE								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)			28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)			29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier Rama Shankar, MD			29c. License number D0048046			29d. Date signed (Month, Day, Year) 10-16-00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) RAMA SHANKAR, 201-109 BACK RIVER NECK Rd, Ba, MD 21221								
31. Date filed (Month, Day, Year) OCT 18 2000			32. Registrar's Signature Geneva B. Sparks					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32960

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hazel Francis Stinnett

2. Date of Death

October 13 2000

3. Time of Death

11:50 AM

4a. Facility Name (If not institution, give street and number)

St. Agnes Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

213 26 8646

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 6 1932

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State  
MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

516 N. Arlington

10f. Zip Code

21223-1307

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Physical Therapist Tech

16b. Kind of Business/Industry

Physical Therapy

17. Father's Name (First, Middle, Last)

Joseph C. Stinnett, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Martha A. Brown

19a. Informant's Name/Relationship (Type, Print)

Karen Lee / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

516 N. Arlington Baltimore, MD 21223-1307

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arbutus Memorial Park 10/19/2000 Arbutus, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Gary P. March

22. Name and Address of Facility

Gary P. March Funeral Home P.A.  
270 Fredhillon Pass Baltimore, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Multiple intacts bowel, liver, spleen

Due to (or as a consequence of):

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Atherosclerosis, generalized, marked

Due to (or as a consequence of):

years

c. Hypertensive cardiovascular Disease

Due to (or as a consequence of):

years

d. Renal artery stenosis

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William J. Hicken M.D.

29c. License number

D041964

29d. Date signed (Month, Day, Year)

October 16, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William J. Hicken, M.D. - St. Agnes HealthCare - 900 Caton Avenue - Baltimore, MD 21229

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Name: Stinnett, Hazel  
Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32961

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ELIZABETH MARIE SPILMAN</b>				2. Date of Death Month Day Year <b>October 13, 2000</b>		3. Time of Death <b>7:40am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Greater Baltimore Medical Center</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>213-20-4564</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 24, 1921</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>4100 N. Charles Street</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4 yrs.</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>FRANK GEORGE SCHENUIT</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>HILDA KENNA KOESTER</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>David S. Spilman (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6687 Walnut Wood Circle Baltimore, Maryland 21212</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Druid Ridge Cemetery</b>		20c. Location - City or Town, State <b>10/16/00 Pikesville, Maryland</b>			
	21. Signature of Funeral Service Licensee <i>Donna Stephen Kenner</i>		22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>PULMONARY EMBOLISM</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ALZHEIMERS DISEASE</b> <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>Michael A. Lyons MD</i>				29c. License number <b>D30433</b>		29d. Date signed (Month, Day, Year) <b>10/14/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY GRMC 6701 N CHARLES ST BALTIMORE MD 21204</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature <i>Benita B. Sparks</i>					



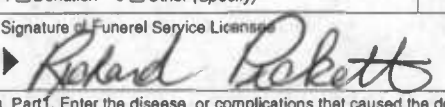
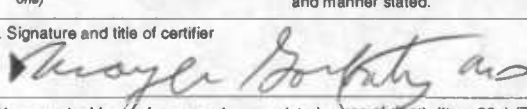

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State of Maryland / Department of Health and Mental Hygiene

00 32962

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PHILIP STEVENS</b>				2. Date of Death Month Day Year <b>OCTOBER 15 2000</b>		3. Time of Death <b>9:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>8327 BROOKWOOD ROAD</b>				4b. City, Town, or Location of Death <b>MILLERSVILLE</b>		4c. County of Death <b>ANNE ARUNDEL CO.</b>	
Funeral Director	5. Social Security Number <b>213-32-9186</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>65</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 09 1935</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md.</b>		10b. County <b>Anne Arundel Co.</b>		10c. City, Town or Location <b>Millersville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>8327 Brookwood Road</b>		10f. Zip Code <b>21108</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>0</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Plumber</b>				16b. Kind of Business/Industry <b>Local Union 486</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Colris Stevens</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sophia Lucas</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Louann Fuller (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7738 Edgewood Ave. Pasadena, Md. 21122</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Cemetery</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Md. 21122</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Non-Small Cell Lung Cancer</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):						Approximate Interval Between Onset and Death <b>18 months</b>	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier 	
	29c. License number <b>0227938</b>						29d. Date signed (Month, Day, Year) <b>10/16/00</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mayer Gorbatz, MD. 785 Agawhock Rd. Glen Burnie, MD 21061</b>							
	31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>						32. Registrar's Signature 	

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 32963

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mariano J Scelsi

2. Date of Death

Month  
OCT.Day  
13Year  
2000

3. Time of Death

12:36 PM

4a. Facility Name (If not institution, give street and number)

121 Riverside Road

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

218-03-9579

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 23 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

121 Riverside Road

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Beth Steel

17. Father's Name (First, Middle, Last)

Salvatore Scelsi

18. Mother's Name (First, Middle, Maiden Surname)

Maria Santa Manzella

19a. Informant's Name/Relationship (Type, Print)

Marie Buck /daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

38 Bladen Road Baltimore MD 21221

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metro Crematory Inc. 10/16/2000

Date

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex

300 MACE AVE. BALTIMORE MD. 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Respiratory Insufficiency

Due to (or as a consequence of):

Approximate

Interval Between

Onset and Death

2 hr.

b.

Mesothelioma

Due to (or as a consequence of):

1 month

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DQA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John J. Loh

29c. License number

H 35593

29d. Date signed (Month, Day, Year)

OCT. 13. 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. JOHN J. LOH

1124 MACE AVE, BALTO., MD. 21221

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

Belena B Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 32964

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jack C Shaffer</b>				2. Date of Death Month <b>October</b> Day <b>13</b> Year <b>2000</b>		3. Time of Death <b>16:30</b>	
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel General Hospital</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>180-28-7108</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>63</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 17, 1937</b>	
	9. Birthplace (State or Foreign Country) <b>PA</b>		10a. State <b>PA</b>		10b. County <b>Lycoming</b>		10c. City, Town or Location <b>Cogan Station</b>	
To Be Completed by Funeral Director	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Aircraft Electronics</b>	
	16b. Kind of Business/Industry <b>Military</b>				17. Father's Name (First, Middle, Last) <b>Jesse C. Shaffer</b>		18. Mother's Name (First, Middle, Maiden Summa) <b>Carolyn Coffey</b>	
	19a. Informant's Name/Relationship (Type, Print) <b>Myrna Jane Shaffer</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>223 Chaapel Mountain RD, Cogan Station, PA 17728</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Oaklawn Cemetery</b>		20c. Location - City or Town, State <b>10/18/00 Eldred TWP, PA</b>		21. Signature of Funeral Service Licensee <b>Robert J. Rodack, Jr.</b>	
	22. Name and Address of Facility <b>Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD 21228</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute Myocardial Infarction</b>			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
29b. Signature and title of certifier <b>Deputy</b>				29c. License number <b>DO6054</b>		29d. Date signed (Month, Day, Year) <b>10/13/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>William P. Jones, MD 695 America Court Shadyside, MD 21035</b>								
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>				32. Registrar's Signature <b>Sparks</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32965

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SARAH ANN SMITH

2. Date of Death

Month Day Year  
OCTOBER 13, 2000

3. Time of Death

9:00 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

JOSEPH RITCHIE HOSPICE CARE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

217-66-6440

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

47

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
9-15-53

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State  
MD

10b. County

BALTIMORE

10c. City, Town or Location

DUNDALK

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2910 YORKWAY

10f. Zip Code

21222

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOMEMAKER

17. Father's Name (First, Middle, Last)

HOWARD SMITH SR

18. Mother's Name (First, Middle, Maiden Surname)

ANNA MAE DOUGLAS

19a. Informant's Name/Relationship (Type, Print)

TAMERIA WILLIS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2335 NORFOLK ST, BALTIMORE MD, 21230

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

METRO CREMATORY INC 10-17-00 BALTIMORE, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

HOWELL FUNERAL HOME  
4600 LIBERTY HEIGHTS AVENUE  
BALTIMORE, MARYLAND 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. INVASIVE MOPHYCOSIS OF SINUSES

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. AIDS

Due to (or as a consequence of):

YEARS

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D06933

29d. Date signed (Month, Day, Year)

10/16/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN B. MACGIBSON 300 ARMORY PLACE Suite 3G BALTIMORE MD 21201

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Sarah A. Smith 10-13-00 9pm  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32966

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Dorothy B. Sturdivant</i>				2. Date of Death Month <i>October</i> Day <i>16</i> Year <i>2000</i>		3. Time of Death <i>6:30 AM</i>	
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN NURSING HOME</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-03-4233</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAY 30, 1910</b>	
	9. Birthplace (State or Foreign Country) <b>NORTH CAROLINA</b>		10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	Usual Residence of Decedent 10e. State <b>MARYLAND</b>				10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6TH</b> College (14 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MACHINE OPERATOR</b>		14. Race - American Indian, Black, White, etc. <b>AFRO-AMERICAN</b>	
	17. Father's Name (First, Middle, Last) <b>WILLIAM BRYANT</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ANNIE</b>		16b. Kind of Business/Industry <b>WESTERN ELECTRIC</b>	
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>WILBERT STURDIVANT, SR (SON)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4231 NORFOLK AVE. BALTO, MD. 21216</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>CRYPT</b>				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WOODLAWN CEMETERY OCT. 19, 2000 BALTO, MD.</b>			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Bernadine V. Kruggs</i>				22. Name and Address of Facility <b>CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Sepsis</b> Due to (or as a consequence of): <b>b. Dementia</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>6 wks</b> <b>1 hr</b> <b>2 wks</b>			
Division of Vital Records, P.O. Box 68760,	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury</b> <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
State Registrar	29b. Signature and title of certifier <i>Quiana K. Trupen</i>				29c. License number <b>D 30661</b>		29d. Date signed (Month, Day, Year) <b>October 16<sup>th</sup> 2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Sitresh TRIPURANENI 5601 Loch Raven Blvd Baltimore, Md - 21239</b>				31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>			
32. Registrar's Signature <i>Quiana K. Trupen</i>				ORIGINAL				





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32967

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT IRVIN TYRRELL</b>				2. Date of Death Month <b>October</b> Day <b>14</b> Year <b>2000</b>		3. Time of Death <b>5:30am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Greater Baltimore Medical Center</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>136-01-9013</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>91</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 3, 1909</b>	
	9. Birthplace (State or Foreign Country) <b>New Jersey</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>6451 N. Charles Street Apt. 206</b>		10f. Zip Code <b>21212</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) <b>12 years</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>District General Manager</b>		16b. Kind of Business/Industry <b>Insurance</b>				
17. Father's Name (First, Middle, Last) <b>James Tyrrell</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ella unk.</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Judy Leutner (niece)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3202 Allness Lane Oak Hill, Virginia 20171</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Crematory</b>		20c. Location - City or Town, State <b>10-17-00 Baltimore, Maryland</b>				
21. Signature of Funeral Service Licensee <b>George J. Ferrante</b>				22. Name and Address of Facility <b>Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pulmonary embolism</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death <b>2 weeks</b>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Rmkh Rekha Motag M.D.</b>		29c. License number <b>D52997</b>		29d. Date signed (Month, Day, Year) <b>10-14-2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Rekha Motag ABMC 6701 N. Charles St. Baltimore, MD 21204</b>								
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature <b>Benue B. Apantaku</b>						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32968

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Neahmiah Teasdel</b>				2. Date of Death Month <b>October</b> Day <b>14</b> Year <b>2000</b>		3. Time of Death <b>7:25 AM</b>	
	4e. Facility Name (If not institution, give street and number) <b>Baltimore VAMC Rehab/Extended Baltimore</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>260-20-3079</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>73</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>12 6 26</b>	
	9. Birthplace (State or Foreign Country) <b>Georgia</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>12 N. Wheeler Ave</b>		10f. Zip Code <b>21223</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4th</b> College (1-4or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Mechanic</b>				16b. Kind of Business/Industry <b>Self employed</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Benjamin Teasdel</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Victoria Thigpen</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Willie Mae Teasdel wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12 N. Wheeler Ave. 21223</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MD Veterans Cemetery</b>			
	20c. Date <b>10/19/00</b>				20d. Location - City or Town, State <b>Baltimore, Maryland</b>			
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>[Signature]</b>				22. Name and Address of Facility <b>Miller's Metropolitan Chapel P.C. 1639 N. Broadway</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Brain Cancer</b>				Approximate Interval Between Onset and Death			
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year) <b>10/19/00</b>				28b. Time of Injury <b>M</b>			
To Be Completed by Physician/Medical Examiner	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred			
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and Title of Certifier <b>[Signature] MD</b>			
	29c. License number <b>D37070</b>				29d. Date signed (Month, Day, Year) <b>10-16-00</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>David J Loreck M.D. Balto VAMC Rehab/Extended Care</b>				31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>			
	32. Registrar's Signature <b>[Signature]</b>				33. State Registrar <b>[Signature]</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 32969

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marie W. Vacchiano

2. Date of Death  
Month Day Year  
October 11 20003. Time of Death  
14:50 P.M.

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre-De-Grace

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

142-07-9956

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

01/04/1917

9. Birthplace (State or Foreign  
Country)

NJ

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Havre-De-Grace

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number

415 South Market Street

10f. Zip Code

21078

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Oliver Van Note

18. Mother's Name (First, Middle, Maiden Surname)

Edna (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Julie Groner Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

106 Whittier Road Brick NJ 08724

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Calvary Cemetery

Date

10/14

20c. Location - City or Town, State

Neptune, NJ

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Sterling Ashton Schwab Funeral Home, Inc.  
736 Edmondson Ave. Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- Dementia

- Depression

- Osteoporosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. Grono MD 34 S. Court St, H&amp;B, MD, 21078

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

James G. Sparks

ORIGINAL

10-11-2000 1450 pm

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32970

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jean Wortham

2. Date of Death  
Month Day Year  
October 15, 20003. Time of Death  
2 PM

4a. Facility Name (If not institution, give street and number)

1312 Appleby Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-24-3648

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept 8, 1933

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1312 Appleby Avenue

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Nelson Caltwider

18. Mother's Name (First, Middle, Maiden Surname)

Christina Paul

19a. Informant's Name/Relationship (Type, Print)

Thomas Wortham Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7523 Bayfront Road, Baltimore, Maryland 21219

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

10/18/00 Woodlawn, Maryland

21. Signature of Funeral Service Licensee

Stacy Henss Carpenter

22. Name and Address of Facility

Burgee-Henss-Seitz Funeral Home, Inc. 21211  
3631 Falls Road, Baltimore, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebro Vascular Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Hem.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Cardiac Arrhythmia

Due to (or as a consequence of):

Years.

c. Diabetes mellitus

Due to (or as a consequence of):

Years.

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Phillip Mac, MD

29c. License number

D 53902

29d. Date signed (Month, Day, Year)

10/16/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Phillip Mac, MD 1447 York Road Lutherville, Maryland 21093

State  
Registrar

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

Beverly Sparks

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32971

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Matthew Washington

2. Date of Death  
Month Day Year

October 13, 2000

3. Time of Death

3:45am

4a. Facility Name (If not institution, give street and number)

Fort Howard VAMC, Fort Howard MD21052

4b. City, Town, or Location of Death

FORT HOWARD

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

214344519

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb 15, 1940

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

11 West 20th Street

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 6/58

6/64

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Steel

17. Father's Name (First, Middle, Last)

James M. Washington

18. Mother's Name (First, Middle, Maiden Surname)

Helena Byers

19a. Informant's Name/Relationship (Type, Print)

Barbara W. Barnwell /Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4014 Glen Ave., Baltimore, Maryland 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Garrison Forest VA Ceme. 10/19/00 Owings Mills, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Derrick C. Jones Funeral Home

4611 Park Heights Ave., Baltimore, Maryland 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE RENAL FAILURE

Due to (or as a consequence of):

ONE WEEK

b. HUMAN IMMUNO deficiency virus disease

Due to (or as a consequence of):

ONE YEAR

c. LUNG CANCER

Due to (or as a consequence of):

TWO YEARS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of injury

(Month, Day, Year)

28b. Time of

injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Marcos, Galicia MD 9600 North Point Road, Fort Howard MD 21052

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

Beverly B. Sparks

State  
RegistrarWashington Charles  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32972

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Andrew H. Woods II</b>				2. Date of Death Month Day Year <b>OCT. 4 2000</b>		3. Time of Death <b>3:21 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland Medical System</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212-34-6103</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <b>Aug 18, 1937</b>	9. Birthplace (State or Foreign Country) <b>ILL</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>5116 Whitefield Avenue</b>				10f. Zip Code <b>21212</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <b>unk</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>unk</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>+5</b>				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>social worker</b>			16b. Kind of Business/Industry <b>education</b>	
17. Father's Name (First, Middle, Last) <b>unk</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>unk</b>				
19a. Informant's Name/Relationship (Type, Print) <b>UMMS</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>22 S. Greene Street Baltimore, MD 21201</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>		20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensed <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multi system ORGAN FAILURE</b> Due to (or as a consequence of): <b>b. LIVER FAILURE Sepsis</b> Due to (or as a consequence of): <b>c. HEAD INJURY</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Sept. 22, 2000</b>		28b. Time of Injury <b>9:20 PM</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>motor vehicle collision</b>
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>STREET</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>5600 ALAMEDA BALTIMORE</b>				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of Certifier <b>Steven J. Schwartz</b>		29c. License number <b>D005380</b>		29d. Date signed (Month, Day, Year) <b>OCTOBER 12, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>STEVEN J. SCHWARTZ MD 22 SOUTH GREENE ST., BALTIMORE, MD 21201</b>								
31. Date Filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature <b>Sparks</b>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32973

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Nancy Wilson</u>				2. Date of Death Month <u>October</u> Day <u>12</u> Year <u>2000</u>		3. Time of Death <u>1:12 PM</u>	
	4a. Facility Name (If not institution, give street and number) <u>St. Agnes Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>	
Funeral Director	5. Social Security Number <u>224-30-8299</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>76</u> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <u>July 29, 1924</u>	9. Birthplace (State or Foreign Country) <u>North Carolina</u>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <u>Maryland</u>		10b. County <u>N/A</u>		10c. City, Town or Location <u>Baltimore</u>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <u>4308 W. Forest Park Ave</u>				10f. Zip Code <u>21207</u>		10g. Citizen of What Country? <u>USA</u>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Negro</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>0</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Nurse</u>		16b. Kind of Business/Industry <u>U.S. Public Health</u>			
	17. Father's Name (First, Middle, Last) <u>unk.</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>unk.</u>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) (Husband) <u>Mr. Johnnie Wilson</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4308 W. Forest Park Ave. Balto. Md. 21207</u>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Carlton Cemetery</u>		20c. Location - City or Town, State <u>Warsaw, North Carolina</u>		20d. Date <u>10/25/2000</u>	
	21. Signature of Funeral Service Licensee <u>Joseph L. Russ</u>		22. Name and Address of Facility <u>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</u>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>Atherosclerotic Cardiovascular Disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
To Be Completed by Physician/Medical Examiner	23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <u>End Stage Renal Disease</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <u>M L Frydenberg</u>				29c. License number <u>170027315</u>		29d. Date signed (Month, Day, Year) <u>October 12, 2000</u>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>St Agnes Hospital</u>							
	31. Date filed (Month, Day, Year) <u>OCT 18 2000</u>				32. Registrar's Signature <u>Sparks</u>			
	33. State Registrar <u>State</u>							

ORIGINAL



1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
LNEZ Williams		Month Day Year		10 12 00 10:50 A.M.	
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
Genesis Elder Care Homewood		Baltimore		N/A	
5. Social Security Number		6. Sex		7. Age (In yrs, last birthday)	
244-34-6351		1 M 2 F		74 Yrs.	
8. Date of Birth		9. Birthplace (State or Foreign Country)		10. Inside City Limits	
Feb. 28, 1926		South Carolina		1 X Yes 2 No	
10a. State		10b. County		10c. City, Town or Location	
Maryland		N/A		Baltimore	
10d. Street and Number		10e. Zip Code		10f. Citizen of What Country?	
828 Bradhurst Rd.		21212		USA	
11. Marital Status		12. Was Decedent Ever in U.S. Armed Forces?		13. Was Decedent of Hispanic Origin? (Specify Yes or No)	
1 X Never Married 2 Married		1 X Yes 2 No		1 X Yes 2 No	
3 X Widowed 4 Divorced		If Yes, Give Year or Dates:		Specify:	
15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry	
Elementary/Secondary (0-12)		College (1-4 or 5+)		Homemaker Own Home	
17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle, Maiden Surname)		19. Informant's Name/Relationship (Type, Print)	
Ulysses Squirewell		Sarah Squirewell		Mrs. Shirley Quillens (daughter)	
20a. Method of Disposition		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State	
1 X Burial 2 Cremation 3 Removal from State		Druid Ridge		10/20/2000 Balto. Md.	
4 Donated 5 Other (Specify)		21. Signature of Funeral Service Licensee		22. Name and Address of Facility	
		Joseph L. Russ		Joseph L. Russ Funeral Home	
		2222 W. North Ave. Balto. Md. 21216			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		23b. Did tobacco use contribute to the cause of death?		23c. Were autopsy findings available prior to completion of cause of death?	
Immediate Cause (Final disease or condition resulting in death)		1 X Yes 2 No 3 Probably 4 Unknown		1 X Yes 2 No 1 X Yes 2 No	
Acute Pulmonary Edema					
Due to (or as a consequence of):					
Arteriosclerotic Coronary Artery Disease					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24e. Was an autopsy performed?		24f. Were autopsy findings available prior to completion of cause of death?	
History of Atrial Fibrillation		1 X Yes 2 No		1 X Yes 2 No	
25. Was case referred to medical examiner?		26. Place of Death (Check only one)		27. Manner of Death	
1 X Yes 2 No		Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify)		1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined	
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury		28c. Injury at Work?	
		M		1 X Yes 2 No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one)		29b. Signature and title of certifier		29c. License number	
1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				D17118	
29d. Date signed (Month, Day, Year)		29e. Signature and title of certifier		29f. License number	
Oct 12, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year)		32. Registrar's Signature	
Paul Schwartz MD 115 E. Melrose Ave 21212		OCT 18 2000		B Sparks	
33. Date of Death		34. Time of Death		35. Location of Death	
10 12 00		10:50 A.M.		N/A	



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State of Maryland / Department of Health and Mental Hygiene

00 32975

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Viola Queen White</i>			2. Date of Death Month <i>October</i> Day <i>12</i> Year <i>2000</i>			3. Time of Death <i>5:30 PM</i>				
	4a. Facility Name (If not institution, give street and number) <i>Future Care Sandtown/Winchester Baltimore</i>			4b. City, Town, or Location of Death <i>Baltimore</i>			4c. County of Death <i>N/A</i>				
Funeral Director	5. Social Security Number <i>218-14-2855</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <i>96</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>Nov. 24, 1903</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>		
	10a. State <i>Maryland</i>			10b. County <i>N/A</i>			10c. City, Town or Location <i>Baltimore</i>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number <i>1506 Presser Ct.</i>			10f. Zip Code <i>21217</i>			10g. Citizen of What Country? <i>USA</i>				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <i>Negro</i>		
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (14 or 5+) <i>8</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>			16b. Kind of Business/Industry <i>Own Home</i>				
	17. Father's Name (First, Middle, Last) <i>Henry Brooks</i>			18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Brooks</i>							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <i>Mrs. Florise White (Caretaker)</i>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1819 N. Mount St. Balto. Md. 21217</i>							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mt. Calvary</i>			20c. Location - City or Town, State <i>Glen Burnie, Md.</i>		20d. Date <i>10/19/2000</i>		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Joseph L. Russ</i>			22. Name and Address of Facility <i>Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216</i>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>congestive heart failure</i> Due to (or as a consequence of): <i>other systemic disease</i> Due to (or as a consequence of): <i>peripheral vascular disease</i>			Approximate Interval Between Onset and Death <i>1 mo.</i> <i>10 yrs.</i> <i>10 yrs.</i>							
To Be Completed by Physician/Medical Examiner	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No							
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicidal <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)			28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner			29f. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>Joseph L. Russ</i>			29c. License number <i>D 29769</i>			29d. Date signed (Month, Day, Year) <i>10/13/00</i>				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Marcelino D. Obispo</i>			31. Date filed (Month, Day, Year) <i>OCT 18 2000</i>							
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <i>Sparks</i>			33. Date of Death <i>10/13/00</i>							
	34. State Registrar <i>Sparks</i>			35. Date of Death <i>10/13/00</i>							

ORIGINAL






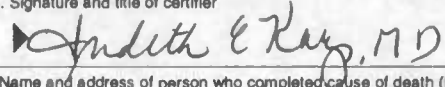

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State of Maryland / Department of Health and Mental Hygiene

00 32976

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT J. WILSON</b>				2. Date of Death Month <b>OCTOBER</b> Day <b>13</b> Year <b>2000</b>				3. Time of Death <b>3:50 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>3802 WEST WOOD MANOR WAY</b>				4b. City, Town, or Location of Death <b>PASADENA</b>				4c. County of Death <b>ANNE ARUNDEL CO.</b>		
Funeral Director	5. Social Security Number <b>217-30-1519</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>2-14-1934</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	10a. State <b>MD.</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Pasadena</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>3802 West Wood Manor Way</b>					10f. Zip Code <b>21122</b>			10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1956-1958</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machinist</b>			16b. Kind of Business/Industry <b>Joseph Seagrams and Sons</b>			
17. Father's Name (First, Middle, Last) <b>James Park Wilson</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Melva Pearl Bray</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Geraldine D. Wilson (Wife)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3802 West Wood Manor Way Pasadena, MD. 21122</b>						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Cemetery</b>			Date <b>10-17-00</b>		20c. Location - City or Town, State <b>Balto., MD.</b>			
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>McCully-Polyniak Funeral Home P.A. 3204 Mountain Rd. Pasadena, MD. 21122</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Refractory Acute Myelogenous Leukemia</b> Due to (or as a consequence of): <b>b. Metastatic Prostate Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b>					Approximate Interval Between Onset and Death <b>3 months</b> <b>2 years</b>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cirrhosis</b>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					29b. Signature and title of certifier 			29c. License number <b>D17912</b>		29d. Date signed (Month, Day, Year) <b>October 13, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JUDITH E. KARP MD 225 GREENE ST BALTO MD 21201</b>											
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>					32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32977

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BETTY MAE WILLIAMS

2. Date of Death

October 13, 2000

3. Time of Death

9:00 AM

4a. Facility Name (If not institution, give street and number)

2 DELL COURE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

227-58-4535

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

1-14-47

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2 DELL COURE

10f. Zip Code

21244

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SUPERVISOR

16b. Kind of Business/Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

GARLAND JOHNSON

18. Mother's Name (First, Middle, Maiden Surname)

HELEN GREENE

19a. Informant's Name/Relationship (Type, Print)

TERESA PRICE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3540 BORN STREAM RD RANDALLSTOWN MD 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NEW JERUSALEM BAPTIST CH

Date

10-21-00

20c. Location - City or Town, State

KINSALE, VA.

21. Signature of Funeral Service Licensee

William E Howell

22. Name and Address of Facility

HOWELL FUNERAL HOME

4600 LIBERTY HILL AVENUE

BALTIMORE, MARYLAND 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

b. breast cancer

Due to (or as a consequence of):

4 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William E Howell, MD

29c. License number

D53077 Maryland

29d. Date signed (Month, Day, Year)

October 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1650 Orleans St. CRB Baltimore, Maryland 21231

31. Date filed (Month, Day, Year)

OCT 18 2000

32. Registrar's Signature

Barbara B. Galt

State Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32978

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>SIDNEY ZERWITZ</b>		2. Date of Death Month Day Year <b>OCTOBER 15, 2000</b>		3. Time of Death <b>1:05 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>MILFORD MANOR NURSING HOME</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>213-10-7384</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>FEB. 21, 1911</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>3403 WINTERSET COURT</b>			10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PHARMACIST</b>		16b. Kind of Business/Industry <b>PHARMACY</b>	
17. Father's Name (First, Middle, Last) <b>LOUIS ZERWITZ</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>ANNA PARISER</b>		
19a. Informant's Name/Relationship (Type, Print) <b>WARREN ZERWITZ / SON</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3403 WINTERSET COURT - BALTIMORE, MD 21208</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>(ANSHE EMUNAH) AITZ CHAIM</b>		20c. Location - City or Town, State <b>10/17/00 BALTIMORE, MD</b>	
21. Signature of Funeral Service licensee <i>Jay Albus</i>			22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>ISCHEMIC CARDIOMYOPATHY</b>		Approximate Interval Between Onset and Death <b>YRS</b>	
Due to (or as a consequence of):		b. <b>HYPERTENSION</b>		<b>YRS</b>	
Due to (or as a consequence of):		c.			
Due to (or as a consequence of):		d.			
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <i>K. J. Jones MD</i>		29c. License number <b>D 20333</b>		29d. Date signed (Month, Day, Year) <b>10/16/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>K. J. JONES MD 1538 GREENBERRY RD PIKESVILLE MD 21208</b>					
31. Date filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature <i>B. Sparks</i>			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32979

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARGARET ZIMMERMAN</b>		2. Date of Death Month Day Year <b>OCTOBER 14 2000</b>		3. Time of Death <b>6:30 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>OAKCREST VILLAGE CARE CENTER</b>		4b. City, Town, or Location of Death <b>BALTO.</b>		4c. County of Death <b>BALTO.</b>
Funeral Director	5. Social Security Number <b>219-30-2691</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>Nov 7, 1910</b>		9. Birthplace (State or Foreign Country) <b>Germany</b>		
Usual Residence of Decedent					
10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>196 West Meadow Rd.,</b>			10f. Zip Code <b>21225</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Housewife</b>	
17. Father's Name (First, Middle, Last) <b>Sebastian Schoder</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Rose (Unknown)</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Joyce Orwig-Granddaughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>321 Sunray Ct., Abingdon, Maryland 21009</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Most Holy Redeemer Cem.</b>		20c. Location - City or Town, State <b>10/17/00 Baltimore, Maryland</b>	
21. Signature of Funeral Service Licensee <b>Kevin E Ecker</b>		22. Name and Address of Facility <b>McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1856</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>Sepsis</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>Weeks</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <b>Leg Ulcers/Gangrene</b> Due to (or as a consequence of):		<b>1 Month</b>	
		c. <b>Peripheral Vascular Disease</b> Due to (or as a consequence of):		<b>years</b>	
		d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Artery Disease</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>CARE CENTER</b>			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Fred Sirkis MD</b>		29c. License number <b>D22645</b>		29d. Date signed (Month, Day, Year) <b>10/15/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FRED SIRKIS M.D. 8800 WALTHER BLVD. PARKVILLE, MD 21234</b>					
31. Data filed (Month, Day, Year) <b>OCT 18 2000</b>		32. Registrar's Signature <b>B. Sparks</b>			

ORIGINAL



REPLACEMENT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

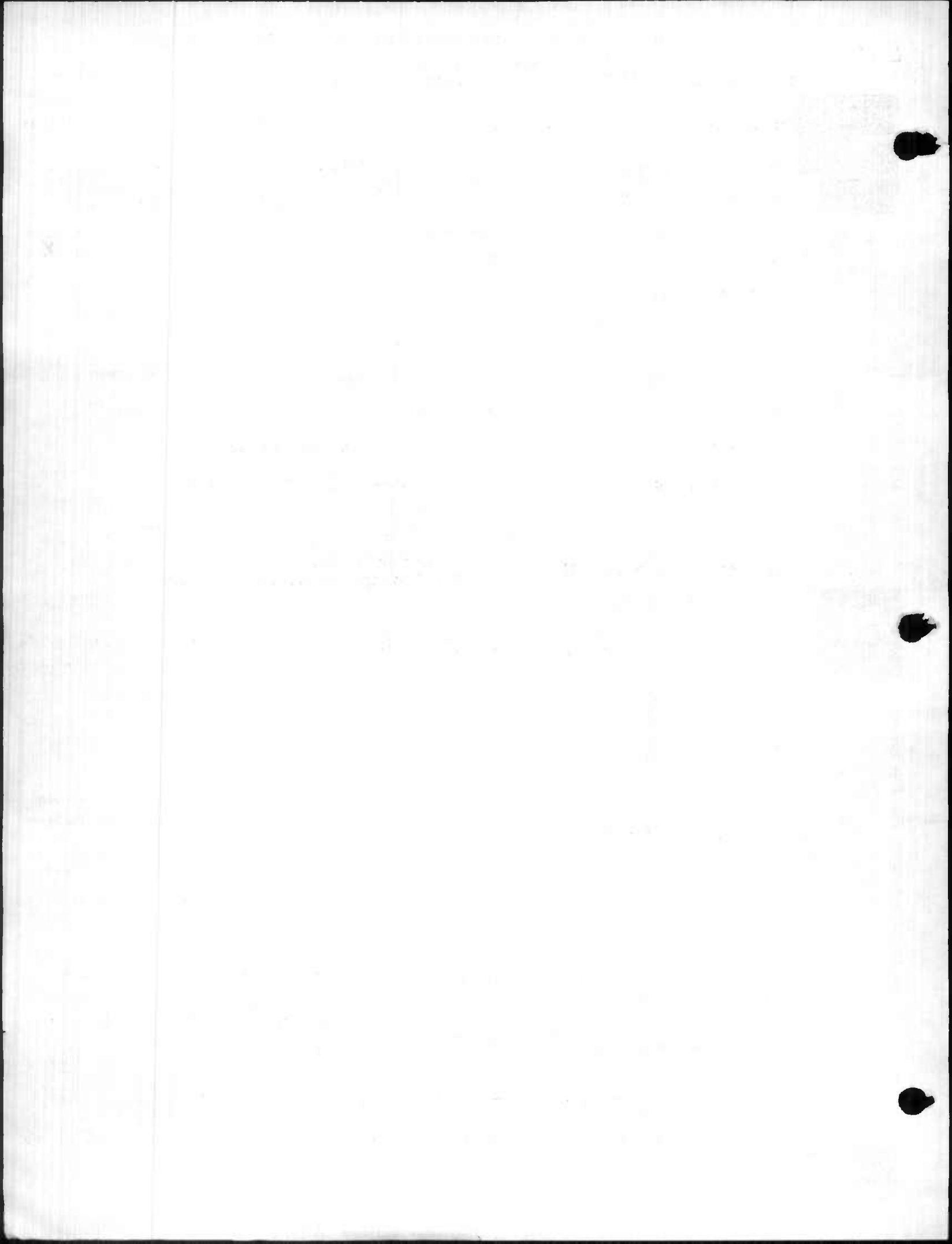
State of Maryland / Department of Health and Mental Hygiene

Amend Items 28a, 28b, 28c, 28d, 28e, 28f per ME, G78810/31/00dhb

Certificate of Death

Reg. No. 0032980

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) THOMAS ATKINS				2. Date of Death Month Day Year OCTOBER 10 2000		3. Time of Death 10 35 AM			
	4a. Facility Name (If not institution, give street and number) NORTH WEST HOSPITAL				4b. City, Town, or Location of Death RANDALLTOWN		4c. County of Death BALTIMORE			
Funeral Director	5. Social Security Number 241-64-3179		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) Sept. 3, 1942		9. Birthplace (State or Foreign Country) North Carolina	
	Usual Residence of Decedent									
10a. State MD		10b. County Baltimore		10c. City, Town or Location Lochearn				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 4122 Buckingham Road				10f. Zip Code 21207		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Auto Worker			16b. Kind of Business/Industry General Motors			
17. Father's Name (First, Middle, Last) George Wattes					18. Mother's Name (First, Middle, Maiden Surname) Louise Barksdale Waddell					
19a. Informant's Name/Relationship (Type, Print) Jean Atkins - Wife					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4122 Buckingham Road, Balto., MD 21207					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Garrison Forest Vet.		Date 10/16/00		20c. Location - City or Town, State Owings Mills, M.D.			
21. Signature of Funeral Service Licensee Herbert E. Nutter, per DVR					22. Name and Address of Facility Nutter Funeral Home Inc. 2501 Gwynns Falls Pkwy., Balto., MD 21216					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <u>INGESTION OF CAUSTIC SUBSTANCE</u> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____  Approximate Interval Between Onset and Death <u>ONE WEEK APPROXIMATELY</u>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>RESPIRATORY FAILURE</u>										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year) Unknown		28b. Time of Injury Unknown M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred Ingestion of corrosive substance	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Home					28f. Location (Street and Number or Rural Route Number, City or Town, State) 4122 Buckingham Road, Balto., MD					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier E. P. Williamson MD					29c. License number D11171		29d. Date signed (Month, Day, Year) OCTOBER 20, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. P. Williamson MD 405 Frederick Road CATONSVILLE 21228										
31. Date filed (Month, Day, Year) OCT 31 2000					32. Registrar's Signature MARYLAND					



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State of Maryland / Department of Health and Mental Hygiene

Amend item#24a perPHYg788 10/19/2000 EW

## Certificate of Death

Reg. No.

00 32981

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Marlene Ruth Barber				2. Date of Death Month Day Year October 12 2000		3. Time of Death 0752	
	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death Baltimore City	
Funeral Director	5. Social Security Number 217 38 7499	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F X	7. Age (In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) May 28, 1940		9. Birthplace (State or Foreign Country) Baltimore Co., Md.
	Usual Residence of Decedent							
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore County		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 2121 Summit Avenue				10f. Zip Code 21237		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Teaching Assistant		16b. Kind of Business/Industry Towson High School		
17. Father's Name (First, Middle, Last) Joseph Leo Mills Sr				18. Mother's Name (First, Middle, Maiden Surname) Evelyn Geraldine Socks				
19a. Informant's Name/Relationship (Type, Print) Earl E Barber (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2121 Summit Avenue Baltimore, Maryland 21237				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Gardens of Faith Cem. October 16 2000		Date October 16 2000		20c. Location - City or Town, State Baltimore, Maryland		
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 2 days	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>[Signature]</i> M.D.				29c. License number Bc4865373		29d. Date signed (Month, Day, Year) 10/12/00		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Earl E Barber, M.D. Union Memorial Hospital								
31. Date filed (Month, Day, Year) OCT 19 2000		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

00 32982

Amend Item#7 per FHG788 10/19/2000 EW

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN BOTZLER				2. Date of Death Month Day Year October 07, 2000		3. Time of Death 2350	
	4a. Facility Name (If not institution, give street and number) Maryland General Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death	
Funeral Director	5. Social Security Number 215-01-4021	6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 79 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Jan 9, 1911		9. Birthplace (State or Foreign Country) unk
	Usual Residence of Decedent							
10a. State MD		10b. County		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 1213 Light Street				10f. Zip Code 21201		10g. Citizen of What Country? USA		
11. Marital Status unk 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? unk 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: white	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk			16b. Kind of Business/Industry unk	
17. Father's Name (First, Middle, Last) unk				18. Mother's Name (First, Middle, Maiden Surname) unk				
19a. Informant's Name/Relationship (Type, Print) Maryland General Hospital				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 827 Linden Ave Baltimore, MD 21201				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state				20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201				
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Gastrointestinal bleed Due to (or as a consequence of): b. Pneumonia Due to (or as a consequence of): c. Atherosclerosis Coronary artery disease Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Adams, MD				29c. License number 89344		29d. Date signed (Month, Day, Year) October 07, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Adams MD, c/o Maryland General Hospital								
31. Date filed (Month, Day, Year) OCT 19 2000				32. Registrar's Signature Beverly G. Sparks				

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State of Maryland / Department of Health and Mental Hygiene

00 32983

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HAZEL ELIZABETH BELL</b>				2. Date of Death Month Day Year <b>OCTOBER 15 2000</b>		3. Time of Death <b>2:00 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>6755 TOWNE BROOK DR. APT F</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>NIA</b>	
Funeral Director	5. Social Security Number <b>217-22-4118</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>SEPT 14, 1922</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>NIA</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number <b>6755 TOWNE BROOK DRIVE</b>		10f. Zip Code <b>21207</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4 or 5+)	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEKEEPING</b>				16b. Kind of Business/Industry <b>SELF-EMPLOYED</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>WILLIAM BENJAMIN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>GRACE BENJAMIN</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>MARIAN DRAKE (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9 POMONA SOUTH #11, PIKESVILLE, MD. 21208</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>DULANEY VALLEY CEMETERY 10-18-00 TIMONIUM, MARYLAND</b>			
	21. Signature of Funeral Service licensee 				22. Name and Address of Facility <b>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD. 21217</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>PNEUMONIA</b>				Approximate Interval Between Onset and Death <b>DAYS</b>			
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>RECURRENT ESOPHAGEAL CANCER</b>				Due to (or as a consequence of): <b>MONTHS</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>M</b> 28b. Time of injury <b>1</b> Yes 2 <input type="checkbox"/> No 28c. Injury at Work? <b>1</b> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>M. VASANTHA KUMAR</b>			
	29c. License number <b>D42510</b>				29d. Date signed (Month, Day, Year) <b>OCT. 17<sup>th</sup> 2000</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M. VASANTHA KUMAR MD. 821 N. EUPHONY ST #407, MD 21201</b>				31. Date filed (Month, Day, Year) <b>OCT 19 2000</b>			
	32. Registrar's Signature 				33. State Registrar <b>State Registrar</b>			

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #29C PER PHY G788 10-20-00 WR.

## Certificate of Death

Reg. No.

00 32984

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LULU BARNES</b>		2. Date of Death Month Day Year <b>October 7, 2000</b>		3. Time of Death <b>6:19 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE, CITY</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>213-36-6701</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>60</b> Yrs.	If Under 1 Year Months Days	8. Date of Birth Month Day Year <b>05-28-40</b>
	9. Birthplace (State or Foreign Country) <b>MD</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>1303 ASHLAND AVENUE</b>		10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 TH GRADE</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MACHINE OPERATOR</b>		16b. Kind of Business/Industry <b>LUCAS BROTHERS</b>
	17. Father's Name (First, Middle, Last) <b>JAMES MAYO</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>MARIE BEECHUM</b>		
	19e. Informant's Name/Relationship (Type, Print) <b>WILLIE BARNES, SR</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1303 ASHLAND AVE., BALTO. MD. 21205</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREEMOUNT CEMETERY</b>		20c. Location - City or Town, State <b>10-14-00 BALTO. MD</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD 21229</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) <b>SEPSIS</b>				<b>3 DAYS</b>
	Due to (or as a consequence of): <b>COLONIC INFARCTION</b>				<b>3 DAYS</b>
	Due to (or as a consequence of): <b>VASCULAR DISEASE</b>				<b>1 YEAR</b>
To Be Completed by Physician/Medical Examiner	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>THROMBOTIC THROMBOCYTOPENIC PURPURA.</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>
			28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier 		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>10-7-00 SEPTEMBER 7, 2000</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MOEEN ABEDIN, M.D. JOHNS HOPKINS HOSPITAL 600 N. Wolfe St Baltimore MD 21287</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>OCT 19 2000</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene 00 32985

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Andy Balko</u>			2. Date of Death Month <u>October</u> Day <u>14</u> Year <u>2000</u>			3. Time of Death <u>8:10 pm</u>		
	4a. Facility Name (If not institution, give street and number) <u>Johns Hopkins Bayview Medical Center</u>			4b. City, Town, or Location of Death <u>Baltimore</u>			4c. County of Death <u>N/A</u>		
Funeral Director	5. Social Security Number <u>193-16-7271</u>			6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (in yrs. last birthday) <u>75</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>Oct. 26, 1924</u>	
	Usual Residence of Decedent			9. Birthplace (State or Foreign Country) <u>Pennsylvania</u>					
10a. State <u>Maryland</u>			10b. County <u>N/A</u>			10c. City, Town or Location <u>Baltimore</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <u>5138 Wright Avenue</u>			10f. Zip Code <u>21205</u>			10g. Citizen of What Country? <u>U. S. A.</u>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <u>White</u>
15. Decedent's Education (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u> <u>8th Grade</u>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Machinist</u>			16b. Kind of Business/Industry <u>Electronics</u>			
17. Father's Name (First, Middle, Last) <u>Steve P. Balko</u>			18. Mother's Name (First, Middle, Maiden Surname) <u>Elizabeth Palaska</u>						
19a. Informant's Name/Relationship (Type, Print) <u>Maxine L. Balko (Wife)</u>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>5138 Wright Avenue, Baltimore, Maryland 21205</u>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Garrison Forest Vets. Cem.</u>			20c. Location - City or Town, State <u>10/17/00 Owings Mills, Maryland</u>			
21. Signature of Funeral Service Licensee <u>Amanda Kelly</u>			22. Name and Address of Facility <u>Schimunek Funeral Home Inc.</u> <u>3331 Brehms Lane, Baltimore, Maryland 21213</u>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <u>HYPERTENSIVE INTRACEREBRAL HEMORRHAGE</u> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):						Approximate Interval Between Onset and Death <u>3 DAYS</u>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HYPERTENSION</u>			23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			29b. Signature and title of certifier <u>Dr. Joseph M. P. Resident Physician</u>			29c. License number <u>P11969</u>		29d. Date signed (Month, Day, Year) <u>OCTOBER 17, 2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Shayy Nagehan</u> <u>4940 Eastern Avenue Baltimore, Maryland 21224</u>									
31. Date filed (Month, Day, Year) <u>OCT 19 2000</u>			32. Registrar's Signature <u>[Signature]</u>						

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



asp  
00-5851-510  
UNK 00-292

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32986

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) TERRY NATHANIEL BROOKS				2. Date of Death Month Day Year OCTOBER 13 2000		3. Time of Death 1430	
4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
5. Social Security Number 220-96-7603		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 20 Yrs.		8. Date of Birth (Month, Day, Year) FEB 5 1980	
9. Birthplace (State or Foreign Country) MARYLAND		10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 2119 N FULTON AVENUE		10f. Zip Code 21217		10g. Citizen of What Country? U.S.A.	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th grade College (1-4or 5+) 11th grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) WORKER		16b. Kind of Business/Industry RETAIL			
17. Father's Name (First, Middle, Last) CLARENCE C BROOKS				18. Mother's Name (First, Middle, Maiden Surname) JANICE M TAYLOR			
19a. Informant's Name/Relationship (Type, Print) Clarence C. Brooks/Father				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2906 ST. Paul St., Baltimore, Maryland 21218			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) MT ZION CEMTERY		Date 10-20-00		20c. Location - City or Town, State BALTIMORE, MARYLAND	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE			
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrhythmia in Association with Cardiac Hypertrophy and ventricular Septal Defect Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number O.C.M.E		29d. Date signed (Month, Day, Year) OCTOBER 14, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201							
31. Date filed (Month, Day, Year) OCT 18 2000		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32987

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Roy Eugene Brunson</b>				2. Date of Death Month Day Year <b>OCTOBER 13, 2000</b>		3. Time of Death <b>6:50 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>VAMHCS FORT HOWARD DIVISION</b>				4b. City, Town, or Location of Death <b>FORT HOWARD</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>247-42-1424</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 26, 1919</b>		
	9. Birthplace (State or Foreign Country) <b>South Carolina</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Glen Burnie</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>7722 Spencer Road</b>		10f. Zip Code <b>21060</b>		10g. Citizen of What Country? <b>U.S.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>W.W. II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3rd</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Truck Driver</b>		16b. Kind of Business/Industry <b>Oil Company</b>		17. Father's Name (First, Middle, Last) <b>David Murray Brunson Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Lucille Barwick</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Joyce Raley / Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7722 Spencer Road Glen Burnie, Maryland 21060</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Md. State Veteran Cem.</b>		20c. Location - City or Town, State <b>10/17/00 Crowsville, Maryland</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. METASTATIC SMALL CELL LUNG CANCER</b> Due to (or as a consequence of): <b>b. END STAGE CONGESTIVE HEART FAILURE</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>17 months</b>			
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  M.D.		29c. License number <b>D41365</b>		29d. Date signed (Month, Day, Year) <b>October 13, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. GEORGE E. WICKS, MD., 9600 NORTH POINT RD, FORT HOWARD, MD 21052</b>		31. Date filed (Month, Day, Year) <b>OCT 19 2000</b>		32. Registrar's Signature 					

ROY E. BRUNSON

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 32988

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Aurelia Adel Brock

2. Date of Death

October 12 2000

3. Time of Death

3:05 PM

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

220 14 5586

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months

If Under 24 Hrs.

Days

8. Date of Birth

Oct. 6, 1924

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2009 Norman Road

10f. Zip Code

21061

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Jeter Benson

18. Mother's Name (First, Middle, Maiden Surname)

Mary Jones

19a. Informant's Name/Relationship (Type, Print)

Mollie Cool / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7756 Overhill Road Glen Burnie, Maryland 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

10/16/00 Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 2122523a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

MD

29c. License number

D43977

29d. Date signed (Month, Day, Year)

October 12 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Casper Dreyer - 301 Hospital Drive, Glen Burnie MD 21061.

31. Date filed (Month, Day, Year)

Oct 19 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32989

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John E. Chaney</b>				2. Date of Death Month Day Year <b>October 15, 2000</b>		3. Time of Death <b>7:50 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>North Arundel Hospital</b>				4b. City, Town, or Location of Death <b>Glen Burnie</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>213-05-9366</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>93</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 22, 1907</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10. Usual Residence of Decedent 10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Pasadena</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10a. Street and Number <b>1074 Johanna Court</b>		10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance</b>		16b. Kind of Business/Industry <b>Transit</b>			
	17. Father's Name (First, Middle, Last) <b>Herbert Chaney</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary (Unknown)</b>		19a. Informant's Name/Relationship (Type, Print) <b>Brenda Joyce Calk / daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1074 Johanna Court, Pasadena, Maryland 21122</b>	
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		20d. Date <b>10/18/00</b>	
	21. Signature of Funeral Service Licensee <b>Ann Y. Zink</b>		22. Name and Address of Facility <b>Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Aspiration Pneumonia</b> Due to (or as a consequence of): <b>b. Adenocarcinoma of the colon</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>2 days</b> <b>unknown</b>	
	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28. Date of Injury (Month, Day, Year) <b>28a.</b>	
	28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Stuart Jacobs MD</b>		29c. License number <b>022483</b>	
29d. Date signed (Month, Day, Year) <b>October 15, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>STUART JACOBS MD 200 Hospital Drive, Glen Burnie, MD 21061</b>		31. Data filed (Month, Day, Year) <b>OCT 19 2000</b>		32. Registrar's Signature <b>B. Sparks</b>		

ORIGINAL



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AMENDED ITEM #11 PER INFORM. G789 11/8/00 AH

State of Maryland / Department of Health and Mental Hygiene

Amend item #24a per PHYG788 10/19/00 EW

Certificate of Death

Reg. No.

00 32990

Henry G. Dodson October 3rd 2000 at 11:30 AM

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Henry G. Dodson</b>		2. Date of Death Month <b>10</b> Day <b>03</b> Year <b>00</b>		3. Time of Death <b>11:30 AM</b>	
4a. Facility Name (If not institution, give street and number) <b>Charlotte Hall Veterans Home</b>		4b. City, Town, or Location of Death <b>Charlotte Hall</b>		4c. County of Death <b>Saint Marys</b>	
5. Social Security Number <b>579-09-2768</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>January 7, 1917</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>		10. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Bowie</b>	
10e. Street and Number <b>2308 Hillman Place</b>		10f. Zip Code <b>20716</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WW II</b> If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Management</b>	
16b. Kind of Business/Industry <b>U.S. Government</b>		17. Father's Name (First, Middle, Last) <b>William Mayo Dodson</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Eva Virginia Bryant</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Glen Muir/ Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2308 Hillman Place, Bowie, MD 20716</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Geo. Washington University Medical Center</b>		20c. Location - City or Town, State <b>Washington, D.C.</b>	
21. Signature of Funeral Service Licensee <b>[Signature]</b>		22. Name and Address of Facility <b>Columbia Mortuary Services, Inc P.O. Box 58007 Washington, D.C. 20037</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>LUNG CARCINOMA</b>		Approximate Interval Between Onset and Death <b>WEEKS</b>			
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>HYPERTENSION DIABETES MELLITUS</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>10/03/00</b>		28b. Time of Injury <b>M</b>	
28a. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify)		28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>D-44436</b>		29d. Date signed (Month, Day, Year) <b>8 October 03 2000</b>	
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>ASHVINKUMAR J PATEL 6B PRESTON SQ II WARDEN MD 20602</b>					
31. Date filed (Month, Day, Year) <b>OCT 16 2000</b>		32. Registrar's Signature <b>[Signature]</b>			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32991

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MICHAEL LEROY EVANS</b>		2. Date of Death Month Day Year <b>October 16 2000</b>		3. Time of Death <b>00:55 A.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>8910 Snow Acres Drive</b>		4b. City, Town, or Location of Death <b>Laurel</b>		4c. County of Death <b>Prince George's</b>
Funeral Director	5. Social Security Number <b>216-60-6680</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>49</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>SEPT. 21, 1951</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		
Usual Residence of Decedent					
10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>3835 SONGBIRD COURT</b>		10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1969-1972</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TAXI CAB DRIVER</b>		16b. Kind of Business/Industry <b>TRANSPORTATION</b>	
17. Father's Name (First, Middle, Last) <b>JOHN CHRISTOPHER EVANS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>FLORANCE RUTH STEINER</b>			
19a. Informant's Name/Relationship (Type, Print) <b>MR. NELSON EVANS (BROTHER)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1405 OAKDALE ROAD, GLEN BURNIE, MD. 21060</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>LOUDON PARK CEMETERY</b>		20c. Location - City or Town, State <b>BALTIMORE, MD.</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>			
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>GUNSHOT WOUND OF CHEST</b> Due to (or as a consequence of):		Approximate Interval Between Onset and Death	
		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b>			
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>10/16/00</b>		28b. Time of Injury <b>0046 AM</b>	
		28c. Injury at Work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred <b>SUBJECT WAS SHOT</b>	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>IN TAXICAB ON STREET</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>8910 SNOW ACRES RD LAUREL, MD</b>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>	
		29d. Date signed (Month, Day, Year) <b>October 16, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARY G. RIPLEY M.D. 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date of Death (Month, Day, Year) <b>OCT 16 2000</b>		32. Registrar's Signature 			



State of Maryland / Department of Health and Mental Hygiene 00 32992  
Certificate of Death Reg. No.

DMMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

00 32993

AMEND ITEM: #30 PER D.V.R. G788 10-20-00 WR.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Sophie Marie Fryer</i>				2. Date of Death Month <i>10</i> Day <i>15</i> Year <i>2000</i>		3. Time of Death <i>5:23am</i>	
	4a. Facility Name (If not institution, give street and number) <i>Maryland Masonic Homes</i>				4b. City, Town, or Location of Death <i>Cockeysville</i>		4c. County of Death <i>Baltimore</i>	
Funeral Director	5. Social Security Number <i>218-46-3481</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>97</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <i>December 8, 1902</i>		9. Birthplace (State or Foreign Country) <i>Baltimore, Maryland</i>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <i>Maryland</i>	10b. County <i>Baltimore</i>	10c. City, Town or Location <i>Baltimore County</i>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <i>1553 Putty Hill Avenue</i>			10f. Zip Code <i>21286</i>		10g. Citizen of What Country? <i>USA</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4or 5+) <i>N/A</i>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Homemaker</i>		16b. Kind of Business/Industry <i>Housekeeping-Own Home</i>		
	17. Father's Name (First, Middle, Last) <i>Edward Joseph Rychtar</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Josephine Christine Jilka</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Nancy F. Green (daughter)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1553 Putty Hill Avenue Baltimore, Maryland 21286</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Parkwood Cemetery</i>		Date <i>October 17, 2000</i>		20c. Location - City or Town, State <i>Baltimore, Maryland</i>	
	21. Signature of Funeral Service Licensee <i>Josephine Christine Jilka</i>				22. Name and Address of Facility <i>Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236</i>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>Cerebrovascular Disease</i>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Severe Dementia, Cerebral atrophy, hco</i> <i>Colon cancer</i>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>R. Jilka, M.D.</i>		29c. License number <i>D21464</i>		29d. Date signed (Month, Day, Year) <i>10-16-00</i>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>ROBERT T. LIBERIO 3508 BANK STREET BALTIMORE, MD 21224</i>								
31. Date filed (Month, Day, Year) <i>OCT 19 2000</i>		32. Registrar's Signature <i>Benjamin S. Sparks</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

00 32994  
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LAURA GILMORE				2. Date of Death Month Day Year OCTOBER 6, 2000				3. Time of Death 1508 PM			
	4a. Facility Name (If not institution, give street and number) 3800 WEST BELVEDERE AVENUE				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death			
Funeral Director	5. Social Security Number UNK		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) Feb 22, 1926		9. Birthplace (State or Foreign Country) unk			
	Usual Residence of Decedent				10a. State MD		10b. County		10c. City, Town or Location Baltimore			
To Be Completed by Funeral Director	10e. Street and Number 3800 W. Belvedere Ave #1022				10f. Zip Code 21215				10g. Citizen of What Country? USA			
	11. Marital Status unk 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4 or 5+) unk				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk				16b. Kind of Business/Industry unk			
	17. Father's Name (First, Middle, Last) unk				18. Mother's Name (First, Middle, Maiden Surname) unk							
	19a. Informant's Name/Relationship (Type, Print) O.C.M.E.				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state				20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State					
	21. Signature of Funeral Service Licensee Ronald S. Wade, Director				22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death) a. <u>Atherosclerotic Cardiovascular Disease</u> Due to (or as a consequence of):											
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
										24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier Dennis J. Chute		
29c. License number OCME										29d. Date signed (Month, Day, Year) OCTOBER 7, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute 111 Penn Street, Baltimore, Maryland 21201												
31. Date filed (Month, Day, Year) OCT 19 2000										32. Registrar's Signature Dennis J. Chute		

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32995

amend item 23a,27,28a,b,c,d,e,f per me G788 10/20/00 yr

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) DONALD GRAHAM		2. Date of Death Month Day Year OCTOBER 06, 2000		3. Time of Death 03:30 AM	
4a. Facility Name (If not institution, give street and number) MARYLAND GENERAL HOSPITAL			4b. City, Town, or Location of Death BALTIMORE		4c. County of Death
5. Social Security Number unk	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 41 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept 20, 1959
9. Birthplace (State or Foreign Country) unk					
Usual Residence of Decedent					
10a. State MD	10b. County	10c. City, Town or Location Baltimore		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10a. Street and Number 312 Martingale Avenue		10f. Zip Code 21229		10g. Citizen of What Country? USA	
11. Marital Status unk 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: unk		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) unk unk			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk		16b. Kind of Business/Industry unk			
17. Father's Name (First, Middle, Last) unk			18. Mother's Name (First, Middle, Maiden Surname) unk		
19a. Informant's Name/Relationship (Type, Print) O.C.M.E.			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Penn Street Baltimore, MD 21201		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) in state		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee Ronald S. Wade, Director		22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. NARCOTIC AND COCAINE INTOXICATION Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) found: 10/6/00		28b. Time of Injury found: 3:00	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred unknown			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) found: dwelling		28f. Location (Street and Number or Rural Route Number, City or Town, State) 2100 Madison Baltimore, Maryland			
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier [Signature]		29c. License number OCME		29d. Date signed (Month, Day, Year) OCTOBER 06, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201					
31. Date filed (Month, Day, Year) OCT 19 2000		32. Registrar's Signature [Signature]			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0026.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32996

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Dehab Gebre - Ab</b>				2. Date of Death Month <b>October</b> Day <b>17</b> Year <b>2000</b>		3. Time of Death <b>8:15 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Milford Manor Nursing Center</b>				4b. City, Town, or Location of Death <b>N/A</b>		4c. County of Death <b>Pikesville</b>		
Funeral Director	5. Social Security Number <b>214-59-1200</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>9-1-33</b>	9. Birthplace (State or Foreign Country) <b>Eritrea</b>		
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>2 Upman Court</b>				10f. Zip Code <b>21228</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Eritrean</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self-employed</b>			16b. Kind of Business/Industry <b>Retail</b>		
17. Father's Name (First, Middle, Last) <b>Gebre-Ab Amine</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Kidusan Wolde - Hawariat</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Alazar Bitsumlak / Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2 Upman Ct. Balto MD 21228</b>					
20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		20c. Location - City or Town, State <b>10-21-00 Balto. MD</b>			
21. Signature of Funeral Service Licensee <b>Rhonda R. Mason</b>				22. Name and Address of Facility <b>Vaughn C. Greene Funeral Services 5151 Balto. Natl. Ake Balto MD 21229</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Multiple Myeloma</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>								Approximate Interval Between Onset and Death <b>2 years</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29c. License number <b>D27034</b>		29d. Date signed (Month, Day, Year) <b>October 18 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Va Hunter Cepelak</b>				<b>1838 Greentree Rd Pikesville MD 21209</b>					
31. Date filed (Month, Day, Year) <b>OCT 19 2000</b>				32. Registrar's Signature <b>[Signature]</b>					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32997

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Frances M. Harvey				2. Date of Death Month Day Year October 13 2000				3. Time of Death 10:45 PM		
	4a. Facility Name (If not institution, give street and number) Livingston Healthcare Center				4b. City, Town, or Location of Death Fort Washington				4c. County of Death Prince Georges		
Funeral Director	5. Social Security Number 579-05-8204		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) APR 17, 1914		9. Birthplace (State or Foreign Country) Georgia		10a. State Maryland		10b. County Prince Georges		10c. City, Town or Location Marlow Heights		
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 3940 Bexley Place Apt #313		10f. Zip Code 20746		10g. Citizen of What Country? USA		11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Cashier		16b. Kind of Business/Industry Hotel		17. Father's Name (First, Middle, Last) William Metcalfe	
18. Mother's Name (First, Middle, Maiden Surname) Algie Hall		19a. Informant's Name/Relationship (Type, Print) Barbara A. Reynolds/Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12801 Pine Tree Lane Fort Washington, MD 20744		20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Inc.		20c. Location - City or Town, State 10-19-00 Baltimore, MD	
21. Signature of Funeral Service Licensee Edward A. Gregorchik		22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cardiac arrhythmia Due to (or as a consequence of): b. Coronary Artery disease Due to (or as a consequence of): c. Myeloproliferative Syndrome Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death 2hr 210yr 2-3yr		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Attending	
29c. License number D-24535		29d. Date signed (Month, Day, Year) 10.19.00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laxmi Berwa 7700 Old Branch Ave. C-101 Clinton, MD 20735		31. Date filed (Month, Day, Year) 10/19/2000		32. Registrar's Signature Sparks		State Registrar	

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 404-388-0000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 32998

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Thomas Walter Hong</b>				2. Date of Death Month <b>Oct</b> Day <b>14</b> Year <b>2000</b>		3. Time of Death <b>0850</b>	
	4a. Facility Name (If not institution, give street and number) <b>488 Derby Court</b>				4b. City, Town, or Location of Death <b>Severna Pk.</b>		4c. County of Death <b>AA</b>	
Funeral Director	5. Social Security Number <b>217-56-6872</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>48</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 16, 1952</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>SEVERNA PARK</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>488 DERBY COURT</b>		10f. Zip Code <b>21146</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1973-1975</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>ELECTRICIAN</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CHEMICAL COMPANY</b>		16b. Kind of Business/Industry <b>CHEMICAL COMPANY</b>				
17. Father's Name (First, Middle, Last) <b>WILLIAM L. HONG</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ADDIE MAY L. HOOD</b>				
19a. Informant's Name/Relationship (Type, Print) <b>MARGARET HONG (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>488 DERBY COURT, SEVERNA PARK, MARYLAND 21146</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MEADOWRIDGE MEMORIAL PARK</b>		20c. Date <b>10/18/2000</b>		20d. Location - City or Town, State <b>ELKRIDGE, MD.</b>		
21. Signature of Funeral Service Licensee <i>Paul Hagan</i>				22. Name and Address of Facility <b>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute Cardiac Insufficiency</b> Due to (or as a consequence of): <b>b. Hypertensive Heart Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestion, Pulmonary</b>								
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>William P. Jones, MD</i> Deputy		29c. License number <b>D 06054</b>		29d. Date signed (Month, Day, Year) <b>10/24/00</b>				
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>William P. Jones, MD 695 America 21035</b>								
31. Date filed (Month, Day, Year) <b>OCT 19 2000</b>		32. Registrar's Signature <i>Sparks</i>						

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

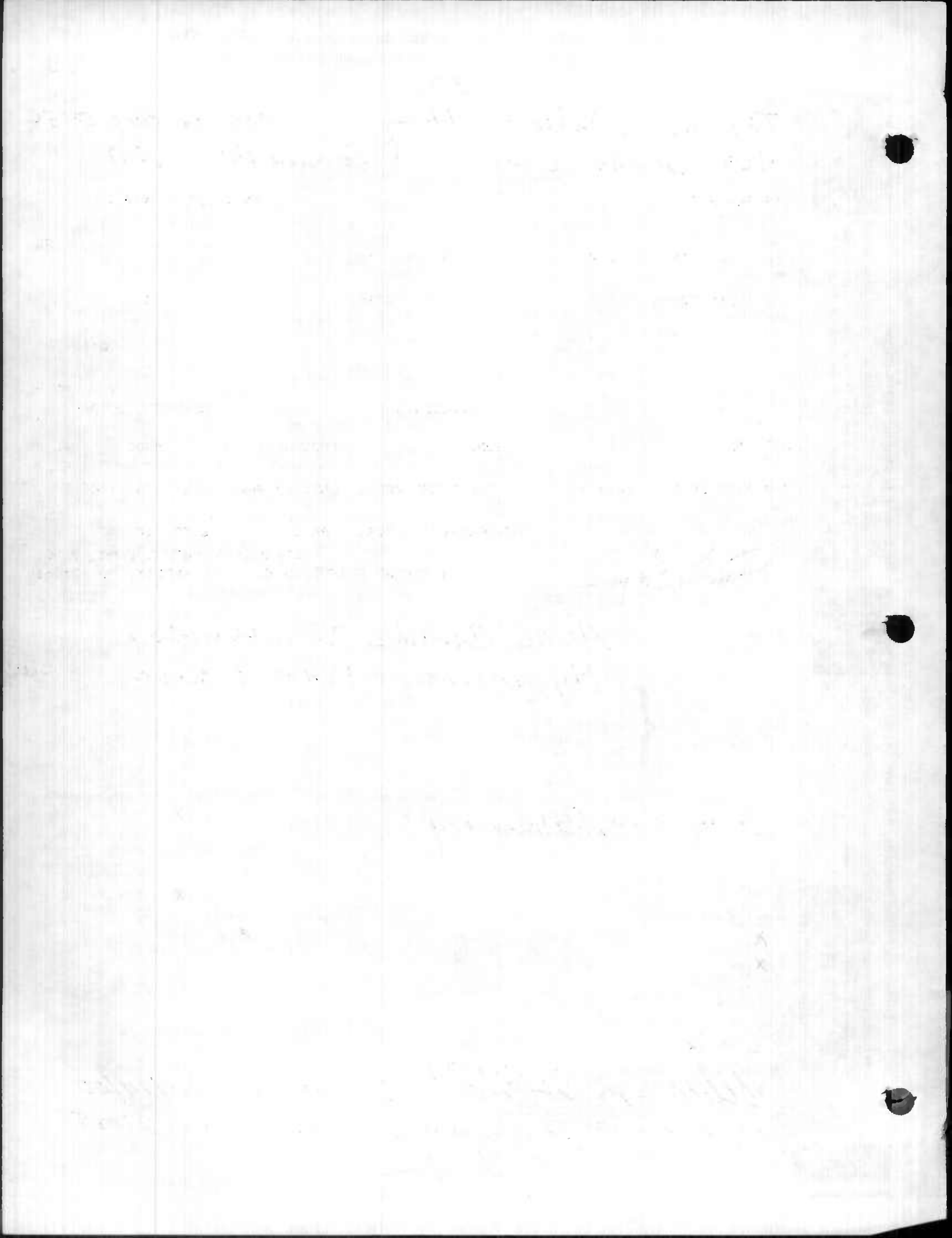
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 32999

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES HAYES</b>				2. Date of Death Month Day Year <b>OCTOBER 16<sup>th</sup> 2000</b>		3. Time of Death <b>6:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>VA MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>n/a</b>	
Funeral Director	5. Social Security Number <b>216-42-9459</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>55</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>SEPTEMBER 14, 1945</b>	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>West Virginia</b>					
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>2625 Wilkens Avenue</b>				10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>6</b>		15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Pressman</b>		15b. Kind of Business/Industry <b>Printing</b>			
	17. Father's Name (First, Middle, Last) <b>Robert E. Lee Hayes</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Janet Ileen Short</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Judy Jones / sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>220 West Arden Road, Baltimore, Maryland 21225</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Mem. Park</b>		Date <b>10/19/00</b>		20c. Location - City or Town, State <b>Glen Burnie, Maryland</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229</b>					
	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Idiopathic Pulmonary Fibrosis</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how Injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>With y kw md</b>		29c. License number <b>P13386</b>		29d. Date signed (Month, Day, Year) <b>October 16, 2000</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Wilbur Kus 32 S Greene St, Baltimore, MD</b>								
31. Date filed (Month, Day, Year) <b>OCT 19 2000</b>		32. Registrar's Signature <b>James B Sparks</b>						

Baltimore, Maryland 21215-0020

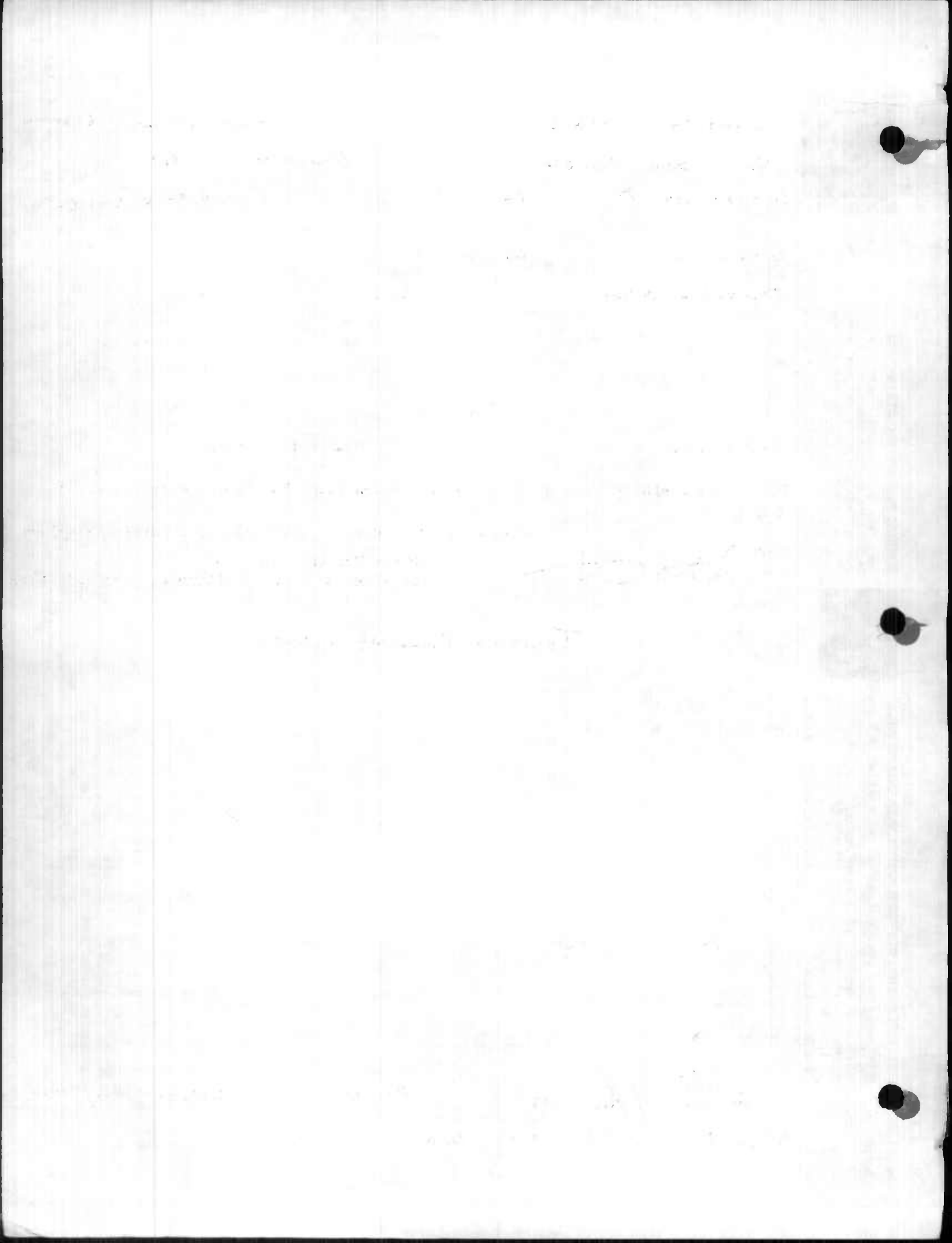
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 33000

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last)

GYEWHAN HAN

2. Date of Death

Month Day Year  
Oct 16 2000

3. Time of Death

11:11 PM

4a. Facility Name (If not institution, give street and number)

Joseph Richey Hospice

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

219-39-6170

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

46 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Dec 12 1953

9. Birthplace (State or Foreign Country)

South Korea

Usual Residence of Decedant

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5 Red Heart Court

10f. Zip Code

21227

10g. Citizen of What Country?

South Korea

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Convenience Store Owner

16b. Kind of Business/Industry

Convenience Store

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Mi Jeong Han / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5 Red Heart Court, Baltimore, Maryland 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

New Cathedral Cemetery

Date

10/19/00 Baltimore, Maryland

21. Signature of Funeral Service Licensee

Ann Y. Zink

22. Name and Address of Facility

Hubbard Funeral Home, Inc.  
4107 Wilkens Avenue, Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Squamous Cell Carcinoma Tongue

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert C. Irwin MD

29c. License number

D08900

29d. Date signed (Month, Day, Year)

10-17-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert C. Irwin MD 828 N. Euterost St. Balt. Md 21201

State Registrar

31. Date filed (Month, Day, Year)

OCT 19 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

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Physician  
/Medical  
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Division of Vital Records, P.O. Box 68760,

11:11 PM

10-16-00

Gye Han HAN

